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Original Articles

SOME EXPERIENCES IN THE SURGICAL TREATMENT OF ULCERS AND CARCINOMA OF THE INTESTINAL TRACT

C. A. HAMANN, M.D.

Professor of Applied Anatomy and Clinical Surgery, Western Reserve University, Cleveland, Ohio

CLEVELAND, OHIO

In this brief paper, it is the intention of the writer to refer to some aspects of the surgery of ulcers and carcinomata of the stomach and of the intestinal tract; needless to say a systematic presentation of the subject will not be attempted; only a few points will be discussed and personal experience with the lesions in question will be the basis of the remarks.

ULCERS OF THE STOMACH AND DUODENUM

In common with numerous other observers, I find that the diagnosis of these ulcers is difficult; the symptoms and physical signs that we are told are diagnostic are not always present. For instance, in at least one-half if not more of the cases of gastric ulcer demonstrated by operation, hyperacidity was not present. The character of the pain and the time of its occurrence were quite variable; in two cases of pyloric ulcer, the patients complained of almost constant pain, which was not influenced by eating. On several occasions I have seen the typical "hunger-pain" of duodenal ulcer caused by lesions of the appendix. In one instance a young male adult had apparently all the symptoms of a duodenal ulcer, including the "hunger-pain"; at the operation an ulcer of the transverse colon was found; adhesions existed between the colon and the duodenum; resection of a portion of the colon and end-to-end anastomosis resulted in relief of the symptoms.

HEMORRHAGE FROM THE STOMACH AND DUODENUM

Having operated on three occasions for hematemesis and blood in the stools, supposed to have come from gastric or duodenal ulcers and not finding any ulcers, I have come to the conclusion that in future I shall refrain from doing so in cases of single attacks of bleeding from the stomach or bowel. As is well known, this hemorrhage ceases spontaneously in 90 to 95 per cent. of the cases, and it is only when the attacks occur frequently that one is justified in operating. Small, non-indurated mucous ulcers and erosions, cirrhosis of the liver, Banti's disease, etc., may be the cause of such single hemorrhages, and operative interference is useless.

PERFORATION OF ULCERS

In the majority of cases, the typical evidences of perforation enable one to recognize the condition, particularly if the patient has been under observation before or if the history points to ulcer. In two instances, however, perforation was the first evidence of the presence of an ulcer, the patients positively denying any symptoms of gastric disturbance; such cases are classed as latent ulcers and undoubtedly exist. In one instance in which we felt certain of a perforated gastric ulcer, the symptoms and signs being apparently characteristic, nothing abnormal was found at operation and in twenty-four hours a lobar pneumonia could be demonstrated; careful examination of the chest prior to operation failed to reveal any thoracic disease. With medical colleagues I have seen several instances of so-called subacute perforation of gastric ulcers; here the evidences of peritoneal involvement were slight; nothing was done surgically and the patients recovered.

Unless an ulcer is found at operation, and if there is no pyloric stenosis as the result of the healing of a former ulcer, gastro-enterostomy should not be done; all writers agree on this point. Some years ago many useless and harm-

ful gastro-enterostomies were done in cases in which we now know the operation should not be performed, as, for example, in gastric atony. Excision of gastric ulcers is, I believe, a wise proceeding. In two instances I have had to resort to partial gastrectomy for pyloric ulcers, for which a gastro-enterostomy had previously been done; the necessity for so doing arose from recurrence of the symptoms, particularly hemorrhage. (The term "pyloric ulcers" is used to designate ulcers in the region of the pylorus, which are perhaps partly gastric and partly duodenal, for it is not always possible to clearly differentiate gastric from duodenal ulcers.)

Duodenal ulcers should always be sewed over, if possible, and the pylorus narrowed or closed, in addition to performing gastro-enterostomy. In one instance an ulcer on the lesser curvature of the stomach was treated by simply turning it in and sewing it over; the patient was not improved; of course, a gastro-enterostomy should also have been done.

In my experience, gastro-enterostomy for cicatricial pyloric stenosis has uniformly yielded the most gratifying results, the patients all recovering and being completely restored to health.

The "posterior, no-loop gastro-enterostomy" is the form of operation which, in common with most writers, I prefer; it is not necessary to place the duodenum so that there will be isoperistalsis, indeed it is not desirable to do so, for the normal course of the beginning of the jejunum is from right to left, and experience has abundantly shown that there is no need of paying any attention to the direction of the peristalsis.

I have had one case of peptic ulcer of the jejunum, following anterior gastro-enterostomy with the Murphy button; the ulcer perforated and death resulted.

There was one death from gastric hemorrhage after excision of a large saddle-shaped ulcer of the lesser curvature and gastro-enterostomy; the patient did quite well for nine days and then had several severe hemorrhages from the stomach which resulted fatally on the tenth day. I have also had a death from perforation of a gastric ulcer after gastro-enterostomy; at the autopsy there were found multiple small ulcers.

The chief benefit of gastro-enterostomy for gastric and duodenal ulcers is to be sought in the diminution of the gastric acidity and not in better drainage.

CARCINOMA OF STOMACH

In the diagnosis of this grave condition an effort has been made to utilize all the clinical and laboratory tests that are available; however, in the majority of cases the diagnosis was comparatively easy, for the patients did not present themselves or were not referred for operation till the characteristic evidence in the shape of vomiting, loss of weight, stenosis of the pylorus, etc., indicated only too plainly the presence of carcinoma.

With regard to the presence of tumor, my experience has been in accord with that of others, in that the size of the tumor is no index of its operability, for a large mass may at times be quite readily removed; two patients in whom the growth was from 2 to 4 inches in diameter have lived two years after partial gastrectomy. Nor can one always judge of the operability of the case from the mobility of the growth, for cases in which the growth was small and freely movable may have extensive metastasis.

Occasionally the presence of hard button-like masses in the umbilicus has aided in the diagnosis, as has also carcinomatous infiltration felt through the anterior wall of the rectum.

In several instances any operation on the stomach would have been impossible, owing to extensive and diffuse carcinomatous infiltration of practically the entire stomach wall.

In several cases, operated on from 8 to 10 years ago, that were regarded as unsuitable for partial gastrectomy, owing to the size of the mass and the adhesions to adjacent structures, gastro-enterostomy has been followed by permanent relief, showing, of course, that carcinoma never really existed and that the mass was the inflammatory thickening around an old ulcer.

In two cases I have seen perforation of a carcinomatous ulcer, followed by death from peritonitis.

I have seen the retroperitoneal metastatic masses, secondary to malignant disease of the testicle, mistaken for carcinoma of the stomach.

Chemical examinations of the stomach contents has not been of much aid to us in the diagnosis of gastric cancer; the results of such examinations are too variable and uncertain. Achylia gastrica, with progressively increasing anemia and loss of weight speaks very strongly for carcinoma. Considerable reliance can be placed on the results of microscopic examination.

When there are good grounds for suspecting the presence of a carcinoma of the stomach an exploratory incision is quite justifiable.

The immediate mortality of partial gastrectomy has been five in twenty-five operations, and while I can not point to any permanent cures, one patient lived five years, two lived over two years and three are alive after about one and one-half years. All the patients that survived the

operation were rendered quite comfortable for a varying period of time and life was undoubtedly prolonged.

Palliative gastro-enterostomy does not yield nearly as satisfactory results as partial gastrectomy; for while the patients may improve for a time, the continued growth of the tumor, the reappearance of obstruction in some cases and the advancing cachexia, all conspire to render the procedure an undesirable one when gastrectomy is at all feasible. The mode of death in patients who have survived partial gastrectomy is usually less distressing than it is in those who have not been operated on at all or who have had merely a gastro-enterostomy done.

The mode of operating has been, in brief, to remove the pyloric portion of the stomach, including always the larger part of the lesser curvature, closure of the duodenum and of the cardiac portion of the stomach and posterior gastro-enterostomy ("Billroth No. 2").

CARCINOMA OF THE INTESTINES

As is well known, carcinoma of the intestines nearly always involves the large bowel, the small intestine is very rarely affected, for reasons that we do not know. Among my cases there was not one in which the small intestine was involved, whereas more than fifty were subjected to operation for carcinoma of the large intestine.

It occurs at the same time of life that carcinomatous disease elsewhere is most common, i. e., between 40 and 60 years of age, though I have had occasion to resect the sigmoid for cancer in a patient aged 21 years, and have seen cancer of the descending colon at 24.

There are three groups of symptoms which point to this affection, namely, those associated with stenosis, in its varying degrees, inflammation of the mucosa, and ulceration with the accompanying discharges. The physical signs which go with the affection will be taken up later.

STENOSIS

Among the earliest evidences of stenosis of the bowel is the pain. This may manifest itself as attacks of colic, which appear at times without apparent cause and at times are the result of errors in diet.

Borborygmi are important symptoms, indicating as they do a narrowing of the gut and increased peristaltic activity on the proximal side of the narrowing; they frequently occur long before visible peristalsis exists. Frequently the pain is localized and the patient can point out the seat of obstruction; the pain usually immediately precedes an evacuation of the bowels or corresponds with that act, or is accompanied with tenesmus. The pain may, however, radiate or be referred, for instance, to the anal region; more often perhaps it is periumbilical or diffuse. It may radiate into the testicle.

There is an important group of cases in which the pressure of the tumor causes pain in the sciatic nerve and the careful physician always examines the rectum in cases of sciatica. As one would expect, the escape of fecal matter and gas usually affords prompt relief in these colicky attacks.

In some cases, certain positions of the body produce or aggravate the pain. It has been noted that colicky attacks have a tendency to occur oftenest at night; this fact has also been noted in colics of other tubular structures such as the bile ducts and the uterus.

Metastasis to certain organs may give rise to continuous pain; for example, I recall a case in which metastasis to the liver—in a case of rectal cancer—caused pain beneath the right costal margin; the secondary growth could not be felt till the abdomen was opened, though it was suspected; and furthermore, the presence of this hepatic pain led me to make an abdominal incision prior to removing the rectum. When a tumor is present in the intestine it is usually painful on handling.

The stenosis leads to progressive diminution of the lumen of the bowel and obstinate constipation, distention of the abdomen, circumscribed peristalsis and later vomiting appears.

In a middle-aged or elderly individual who has been having gradually increasing constipation or perhaps diarrhea alternating with constipation, perhaps an occasional passage of bloody mucus, and who comes under observation when he has complete mechanical obstruction of the bowels, we will nearly always be right if we make a diagnosis of carcinoma of the lower part of the large intestine (oftenest the sigmoid) and that carcinoma will nearly always be of the annular kind, a narrow constricting band of cancer, not palpable because the mass is quite small.

A patient may get over several attacks of apparently complete obstruction before an operation becomes imperative, as I have repeatedly seen. The character of the stools is not distinctive, for neither narrow, tape-like stools, nor small spherical masses of feces, bear any relation to cancer of the bowel. In rectal growths, of course, blod and mucus are apt to occur in the feces at the time ulceration begins and dysentery may be simulated.

Of other organs in the abdomen that may be influenced by cancer of the large intestine, the bladder may be mentioned; pressure on this viscus and fistulous communication may lead to frequent urination, tenesmus and escape of gas and feces from the urethra. In my experience bladder complications have been very rare.

Metastasis to other organs is rare, if we except the liver, in cases of rectal cancer. The infrequency of organ metastasis and the good surgical accessibility of cancer of the large intestine, in many cases at least, are among the reasons for the importance of an early diagnosis. If that is made, surgery holds out a fair prospect of cure, or at least relief.

I have been struck with the intermittent or remittant character of the symptoms in a number of cases, that is to say, a period of partial obstruction will be followed by days during which there are fecal evacuations like those of dysentery, and then there will be a period of normal bowel movements; weight which has been lost may be partly regained and so the symptoms may for a while alternate. In another group of cases, the evidences of stenosis are continuous and gradually progressive in severity. I have known patients of this kind to be treated for spastic constipation.

In still another group of cases the first evidence of the disease is an acute mechanical obstruction of the bowels.

PHYSICAL EXAMINATION

The simplest mode of investigation for the purpose of ascertaining the existence of carcinoma of the large intestine is, of course, a digital examination of the rectum. In common with other surgeons I have to comment on the frequency with which this is neglected, and the patient perhaps treated for piles or constipation when a digital examination would have cleared up the case and given surgery an opportunity to obtain a better result. Not only may rectal cancer be thus found, but growths 14 inches from the anus may be felt through the rectal walls. The sigmoid flexure is movable and varying degrees of abdominal distention may, along with this mobility, change the position of the growth, so that repeated rectal examinations are advisable. It will at times be noted that the rectal ampulla is enlarged, that so-called "ballooning" of the rectum exists; this is suspicious of a high rectal or a low sigmoid carcinoma.

In the examination of the abdomen we look for circumscribed intestinal dilatation and peristalsis, note irregularities in the abdominal contours, etc.

In palpating the abdomen it is particularly the four corners of the abdomen, namely, the right and left hypochondria, and the right and left iliac regions that we examine, for here carcinoma is most common. In the right iliac fossa we may mistake an ileocecal tuberculosis, or a chronic appendicitis for a cancer of the sigmoid. There are cases of subacute appendicitis with large exudates that may suggest malignant disease. However, it is more likely that a cancer of the bowel will be called appendicitis. In an elderly individual having a mass in the right iliac fossa, with or without fever, we have to try to differentiate between appendicitis, ileocecal tuberculosis and malignant disease. In carcinoma the mass is apt to be more circumscribed and movable than in appendicitis.

In one case I removed a sarcoma of the cecum; this diagnosis had, of course, not been made.

When the mass is in the region of the ascending or descending colon renal enlargements must be differentiated; I once diagnosed a carcinoma of the descending colon and found at operation a retrocolic cyst about the size of a small baseball; in another case, after diagnosing carcinoma of the descending colon, I found an inflammatory tumor of the great omentum, which compressed the colon and gave rise to partial obstruction. Inflammatory tumors of the large intestine itself may give rise to all the signs and symptoms of carcinoma, and one can not differentiate them even when they are exposed. In one case I removed about 14 inches of the rectum and sigmoid for what I regarded as a carcinoma, and subsequently learned from the pathologist that the mass was inflammatory in origin. In another case it seemed that a carcinoma involved the sigmoid and left uterine appendage; removal was impossible and I established an artificial anus; the subsequent clinical history and the pathologic report on a small piece of the mass which had been removed showed the growth to be inflammatory in character. Cases in which an exploratory operation has been done, an apparently inoperable cancer found and the wound closed—the patient subsequently recovering and remaining well—are every now and then met with and are to be explained by the inflammatory character of the supposed neoplasm. Syphilis of the intestine may also simulate cancer.

A mass in the hepatic flexure of the colon may resemble an enlarged gall-bladder or some hepatic lesion. When the splenic flexure is involved, the mass, unless quite large, is hard to feel, owing to its being covered by the lower ribs; it may sometimes be rendered more accessible by rolling the patient over to the right.

Resection of a portion of the large intestine for neoplasm, in the presence of acute obstruction, is usually inadvisable; the obstruction should be temporarily relieved and later on a resection can be made. One can not insist too strongly on the importance of washing out the stomach prior to operation for obstruction with vomiting; neglect of this precaution in one of my cases resulted in the death of the patient, owing to the entrance of the fecal matter into the bronchial passages. Great care is necessary in handling the distended bowel, for it is an easy matter to cause laceration and perforation of the wall.

In cases of carcinoma of the cecum I have followed the plan of removing the cecum, a large part of the ascending colon and 4 or 5 inches of the ileum, together with the lymph glands into which these parts drain; the divided ends of the intestines are then closed and a lateral anastomosis is made between the lower ileum and the transverse colon. The parts of the large intestine that are not entirely surrounded by peritoneum do not lend themselves readily to end-to-end anastomosis.

Carcinoma of the splenic flexure I have found is often difficult to treat by resection, as this part of the gut is high up under the ribs and is difficult to free thoroughly. In four cases a short-circuiting operation was done, i. e., the lower ileum was anastomosed with the sigmoid flexure; one of the patients lived in comparative comfort for thirteen months; in two others the accumulation of gas in the cecum and ascending and transverse colons caused much discomfort during the few months that the patients survived the operation; the fourth patient is only just recovering from the operation.

Carcinoma of the rectum has usually been treated by removal through the perineum. I have removed as much as 14 inches of the rectum and sigmoid by the perineal operation alone. Resection of the sacrum has been given up, though the coccyx is usually removed; in none of my cases, unfortunately, has there been satisfactory sphincteric control after the operation, though perhaps the majority are not troubled much with incontinence unless diarrhea exists. One advantage of the combined perineal and abdominal operation is the ability of the surgeon to determine the presence of secondary deposits in the liver; when these are found, of course, extirpation of the rectum should not be done. In two cases a very satisfactory result was obtained by first making an iliac colostomy and then removing the rectum and closing the lower end of the sigmoid.

Fully one-half of the cases of carcinoma of the rectum that came under my observation were too far advanced for a radical operation; when obstruction existed, of course, an artificial anus was made and there is no question that this procedure has frequently prolonged the patient's life.

In only three out of twenty-five cases of removal of the rectum have the patients lived more than three years.

HYPERTHYROIDISM, ITS MEDICAL AND SURGICAL TREATMENT *

F. B. MARSHALL, M.D.
MUSKEGON, MICH.

The economic importance of this disease is great in our state of Michigan, where cases may be found in every community.

CAUSES

Rudinger, Falta and Eppinger believe that Graves' disease is the result of combined hypersecretion and nerve irritation, acting simultaneously and independently. In addition, the internal secretion of at least the adrenals, the thymus, the hypophysis and the sexual glands must also be considered as etiological factors. So that it would seem that in the thyroid gland there is found the final reaction of nervous internal secretory and local (thyroid) processes.[1] All observers have noted the disastrous effects of excitement from external causes to hyperthyroid patients; also the good effect of freedom from worry and restful quiet.

The generally accepted symptoms of hyperthyroidism are, fine nervous tremor, tachycardia, exophthalmus, enlargement of gland. In addition, other associated symptoms, constant or inconstant, are seen, such as diarrheas, sometimes of fatal character, increased secretion of sweat, vasomotor disturbances, flushing, edema, pigmentation, emaciation and muscular weakness, and enlargement of the spleen. It is to be borne in mind that any one of the characteristic symptoms of the disease may be absent; further, that other varieties of goiter and cysts and tumors of the thyroid gland may be associated with the symptoms of hyperthyroidism, having existed many years previous to the onset of hyperactivity of the gland.[2] Mental derangements are often encountered in these cases, and are of periodical character, in which hallucinations are entertained

* Read before the Calhoun County Medical Society, May 6, 1913.

1. Forcheimer.
2. A. B. Johnston.

quiet constantly with excitable mania occurring at intervals; these symptoms occur only in extreme cases. Hysteria is quite common.

Schlesinger of Berlin has noted cases in which 20 pounds weight was lost in one month and one patient lost two-thirds of his weight in eleven weeks. These were cases in which food was mechanically restricted; but instances of rapid and great loss of weight occur in gastric crisis, as noted in Case 4.

Splenic enlargement is an early symptom. The temperature is often found two or three degrees above normal in acute cases, and one-half or one and one-half degrees above normal in chronic cases.

Even in those cases in which the gland appears rather smaller than normal a vascular bruit can be heard over the gland. This bruit is soft but unmistakable, with rhythmical systolic accentuations.

In the early stages, exophthalmus may not be perceptible, though it sometimes develops very soon after the first symptoms appear. Leucopenia with relative lymphocytosis is always present in both acute and chronic cases.

An acute case presenting no perceptible enlargement of the thyroid gland, if associated with fever and enlargement of the spleen, may easily be mistaken for typhoid fever until special tests for typhoid have been made. The condition may resemble typhoid still more closely if a gastro-intestinal disturbance is present. Intense icterus may occur; also glycosuria, though the presence of these associated symptoms has not been explained; in fact, the exact function of the thyroid has not been fully explained.

Much has been written of the physiology and pathology of the thyroid, but our present knowledge of this gland—so essential to our existence—is well expressed by Wm. Carpenter McCarthy, Pathologist of the Mayo Clinics, in these words: "Very little is known about the etiology, or indeed, the physiology of the gland itself."

Our treatment of hyperthyroidism has been and must be largely empirical until more is learned of the physiology of the gland.

Crile has demonstrated the destructive effects of hyperthyroidism on the heart muscle, producing dilatation; on the liver, fatty degeneration; on the brain-cells, destruction of the brain-cells which can never be repaired or replaced.

Many cases recover with medical treatment. Some cases have been known to recover without treatment of any kind; and others in spite of treatment generally believed to be very bad.

We have learned enough regarding the pathology of exophthalmic goiter to understand how nature endeavors to correct the hyperthyroidism by colloid formation; and, in case the patient survives through the long period of time required by nature to effect the change, which is many years, the condition is sometimes changed from hyper- to hyposecretion, and overcorrection of the trouble causing myxedema.

TREATMENT

Treatment is most simply classified as non-surgical and surgical. Non-surgical treatment includes rest, warm salt-bath, massage of body (not the gland), soothing currents of electricity, application of x-ray (although Von Eiselsberg calls attention to the fact that the x-ray increases connective-tissue formation about the gland and thus renders operation much more difficult), an easy digested, nutritious diet (meat excluded and alcohol and tobacco interdicted), application of ice over the gland, optimistic suggestions, pituitrin (1 c.c., two or three times daily, hypodermatically) with small doses of pilocarpin until marked improvement in heart action occurs; then hydrobromid of quinin (gr. 5) and ergotin) gr. 1) four times daily (Forcheimer). The value of serums has not been proven. Thyroid and thymus extracts usually aggravate symptoms.

The permanent benefit of non-operative treatment is found in a large percentage of mild cases, some claiming as high as 90 per cent., when treatment is begun early.

Any case that does not improve under non-operative treatment and does not continue to improve until all symptoms have disappeared, should be operated; as also cases showing symptoms of compression, patients who continue to lose weight, when fever persists, when tachycardia cannot be controlled, or when the disease renders the patient unfit to pursue his vocation. It is very wrong to encourage a patient to employ non-operative treatment until organic heart-changes, or fatty degeneration of the liver or destruction of brain-cells has taken place. Very bad general condition of the patient—or a pulse rate of 130 to 150—contraindicates radical operative procedure, until improvement occurs. In such cases that do not improve, ligation of the upper poles of the gland under novocain may be done, which usually produces marked improvement very promptly; or injection of boiling water as suggested by Porter may be employed.

Operative treatment is successful in fully-developed thyroidism and the improvement is permanent in 76 to 95 per cent. of cases.

Kocher says: "In our present-day knowledge of surgery of the thyroid, there may be no mortality from operation." In the author's list of thirty-one operations, there has been no mortality or post-operative complications, or recurrences in the twenty-two heard from. The curative effects of simple ligation are sometimes permanent; but the majority of ligations must be followed by removal of part of the gland.

Frequently the improvement of symptoms after ligation ceases in four to eight weeks, and the surgeon is aware that unless a part of the gland is removed the patient will relapse into his former distressing condition and probably become inoperable if long delayed.

The confidence of the patient in the surgeon is very important. If the patient should become panicky or hysterical immediately before operation, the operation should be postponed until the patient is calm and hopeful.

Crile has given us many valuable suggestions concerning the management of these patients previous to operation, such as minimizing the dangers when conversing with the patient, starting the anesthetic several times before operation and not telling the patient exactly when the operation would be done, also blocking the nerves to the field of operation with a local anesthetic to prevent impressions of pain reaching the brain and thus lessening shock.

It is desirable that the patient be in the best possible general condition at the time of operation.

TECHNIC OF OPERATION

Iodin sterilization of skin is employed, and after operation the skin is bathed with alcohol.

I prefer the transverse collar incision through skin, fascia and platysma, after which the sternohyoid and thyroid muscles are separated by blunt dissection and held apart by retractors, which usually gives ample exposure.

I have never found it necessary to cut the muscles. The lateral veins are first ligated, over a Kocher dissector, close to the capsule and cut between ligatures. The stumps of these vessels, together with the surrounding fascia, are grasped with forceps and traction made inward and upward and the lateral and posterior surface of gland freed to the capsule by gauze dissection, all vessels being cut between ligatures over the Kocher dissector. The superior vessels are now secured in the same manner and the inferior vessels treated likewise. The isthmus is divided between clamps and the posterior capsule dissected free from the gland and allowed to remain, covering the recurrent laryngeal nerve. In case cysts are found in the remaining lobe they are dissected out, leaving the gland tissue, and the cavity sutured with lock-stitch to prevent hemorrhage. The gland is not squeezed and is manipulated as little as possible. The stump of the isthmus on the remaining lobe is cauterized and sutured. The cavity is carefully packed with iodoform gauze, the end of which is placed through a spirally-cut rubber tube, which is placed in a stab-wound in the suprasternal notch. The thyroid and sternohyoid muscles are brought together by two or three interrupted sutures and the platysma and subcutaneous fascia carefully sutured in place to prevent stretching of the scar and the edges of the skin approximated with the Michel clips. An ample quantity of sterile gauze is applied, which is changed every eight hours, while active drainage occurs. Pituitrin is administered for forty-eight hours. Liquids are allowed *ad libitum,* and solid food as soon as patient can swallow comfortably. The patient is allowed any position desired and encouraged to sit in a chair in twenty-four to forty-eight hours after operation.

CASE REPORTS

The following case reports are selected as typical of the most common conditions found:

CASE 1.—Mrs. H., aged 44. Hairdresser. Native of England, mother of two children, both living. Total hysterectomy at 34, for malignant growth of cervix. Goiter developed at 15. Symptoms of hyperthyroidism developed at 27, after birth of second child, with exacerbations and remissions until operation, Nov. 6, 1900. Dilatation of heart marked. Recovery uneventful, but improvement of symptoms was slow. Normal health was not restored until five months after operation.

CASE 2.—Mrs. R., age 24, married three years, mother of two normal children. Thyroid slightly enlarged since 14 years of age. No symptoms of hyperthyroidism until four months after birth of first child, 1908. Symptoms developed gradually; nervousness, tremor, tachycardia, weakness and sweating; with development of second pregnancy, March, 1909, symptoms of hyperthyroidism disappeared until one month after birth of child, Nov. 8, 1909, when exophthalmus developed, and the previous hyperthyroid symptoms became very distressing. Patient lost weight rapidly and became very weak. Operation March 30, 1910. Right lobe and isthmus removed, uneventful recovery, with prompt disappearance of all symptoms, and rapid gain in weight.

CASE 3.—Miss H., age 21, student. Personal and family history unimportant. No members of family have goiter. Enlargement of gland first noticed at 15, at which time menstruation first appeared. Symptoms of hyperthyroidism first

noticed at 18, with exacerbations and remissions (which continued three years). Depressive melancholia developed. Exophthalmus marked. Tachycardia with pulse 130. Operation Aug. 26, 1911, right lobe removed. Left hospital third day. Prompt recovery and subsidence of all symptoms.

CASE 4.—Mr. P. Cabinetmaker, age 28. Native of Sweden—six years in America. Personal and family history unimportant. Slight enlargement of thyroid first noted October, 1911. Began medical treatment May, 1912, at which time fine nervous tremor was noted. Patient noticed nervous symptoms in April, 1912, about one month before beginning treatment. During latter part of May had an attack of gastric crisis and lost 35 pounds in one week. Patient's normal weight had been 175 pounds until symptoms became worse and mania developed, lasting ten days, and weight fell to 110 pounds, during December, 1912, and January, 1913. Tachycardia appeared with first symptoms, and profuse sweating occurred. Extreme weakness developed about this time. Patient continued in state of extreme excitement, but because of slight remission of symptoms and financial necessity he worked in factory five and six hours daily for two weeks in March, and then suffered recurrence of all symptoms (which he attributed to taking "cold"). At request of family physician, patient consulted author April 24, 1913. Complete rest, ice to neck, pilocarpin and pituitrin reduced pulse from 150 to 100, with one week's treatment, and markedly improved patient's general condition.

Enucleation of right lobe of thyroid April 2, 1913. Marked improvement of all symptoms were noticed in twenty-four hours. Improvement continued uninterrupted and patient left hospital four days after operation so much improved that he declared himself perfectly well. Temperature 98, pulse 70, respiration 18 per minute, incision nicely healed.

Drainage tube removed fourth day, but some drainage occurred for three weeks. Patient has gained 25 pounds in about four weeks since operation, and is working.

THE LIABILITIES OF THE PHYSICIAN AND SURGEON TO THE PUBLIC *

O. E. CHASE, M.D.
TRAVERSE CITY

This subject, which is of such great importance to us all and yet so little discussed, I wish to bring before you for the purpose of bringing out a discussion on the various points as a matter of benefit to us as physicians. I cannot deal with the subject to the extent that its importance demands, but will only try to bring out the important points as food for further study.

We do not, as a rule, realize how often we make ourselves liable, according to law, in the performance of our daily duties to the sick. We are at all times doing the best that we can according to our intelligence, the means at hand, the willingness of the patient and as their surroundings will permit. The law makes no allowance for lack of knowledge, nor for neglect of duty as viewed according to popular idea. Our intent does not in the least extenuate us, but our results hold us, according to law — mere inference will not suffice.

Our position in regard to the public is a very grave one, if we but recognize our responsibility. We are liable for errors of omission as well as for those of commission, and yet the latter are more apt to be looked on by the public as our greatest errors. Our duties to the public are not all legal, by any means; our moral duty to our patients is of the greatest importance, but I wish to deal largely with the legal phase of the subject in this article.

We are looked on, and rightly, as a body of health-preserving individuals, as well as those who administer relief from illness and pain. We therefore bear a definite liability to our city and our country to do all that we can to preserve the health of the community in which we reside; however, we are not held legally responsible for epidemics unless it can be proven that we are the source or carriers of contagion.

Liabilities may be civil or criminal. Malpractice may be civil or criminal. It may be wilful, negligent or ignorant. Medical malpractice means the unskilful treatment, by a professional person, such as a physician, whereby the patient's health is injured or death follows the treatment. Wilful or criminal malpractice consists in the administering of a drug, or the performance of an operation, by a physician or surgeon, which he knows or expects will end in injury or death. Negligent malpractice consists in the gross negligence or failure to render that attention to the patient which his condition requires, by a physician or surgeon, but lacking criminal or dishonest motives.

Negligence has been declared to be the omission to do something which a responsible person, guided by those considerations which ordinarily regulate the conduct of human affairs, would do, or the doing of something which a reasonable or prudent person would not do. Ignorant malpractice consists of the administration of medi-

* Read before the Grand Traverse-Leelanau Medical Society, May, 1913.

cine or the performance of operations which do injury and which an educated physician or surgeon would recognize as unsuitable.

We are expected to use ordinary care, skill and diligence in the treatment of our patients. This means the ordinary care, skill and diligence which is commonly practiced by physicians in the same neighborhood and in the same general practice.

We are held responsible, as I have said, for acts of omission. For instance, if a physician be called on to treat a patient and he does not make a careful examination to find the cause of the trouble, and it later develops that the patient is suffering from a serious malady, the nature of which he has not been told in time to take proper measures for the treatment of such malady, then the physician may be held liable for ignorant malpractice. We cannot be too careful or too thorough in our examinations. I think that in many instances, through gross carelessness, we are apt to omit a careful and thorough examination, thus not only making ourselves liable for the charge of ignorant malpractice, but also making the future treatment of the patient much more difficult.

In cases of criminal abortion we are many times placed in trying positions. Criminal abortion may have been begun by the patient herself, or by some individual acting with her consent, and it is usually only when conditions are unfavorable and the patient in a critical state that we are called in. If the physician himself commits the abortion, he is surely liable.

We will do well to bear in mind the following points in the New York state law regarding abortion—similar to the Michigan law—perhaps best illustrated in the form of question and answer.

"Is it the duty of a physician to inform the officers of the law that an abortion has been produced illegally?" "Does he render himself a party to the crime under the law if his information is not forthcoming?" "It is, of course, a moral duty for every individual to assist as far as possible in the detection of crime and the bringing of the guilty to punishment. It therefore follows that a physician's duty to report a case of illness which he suspects to involve criminal malpractice is not a duty imposed on him by any statute; and that for his failure to so report, considered by itself alone and apart, he is not liable to any specific punishment."

Further, "Theoretically speaking, the position of the physician is impregnable and his immunity complete. From a practical standpoint, however, if the patient dies and the circumstances be such as to lead anyone to believe that malpractice has been committed, he runs a grave risk of the suspicion of being an accessory. His duty, under the circumstances, then relates only to himself and his conduct should be such as to conduce to his own protection."

"Where the patient is in the house of a midwife, or where there is the slightest reason to believe that a criminal act has been committed or that death might ensue, it is then an imperative duty for the physician to provide himself with the services of a consultant, whose evidence, added to his own, should suffice to prove the integrity and wisdom of the treatment. In all that we do, we should be open and above-board, so that suspicion, if any arise, may be disarmed. This is, after all, all the advice that can be given."

"The New York law specifically states that no physician or surgeon shall be allowed to disclose any information which he has acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity. This law is practically the same in all the states. It would seem, from a casual observation of the law, to protect crime, but it is interpreted quite differently in criminal cases; but is stated as it is to protect the public from slanderous statements which might be made by a physician in general cases. If, in performing his duties in criminal cases—as far as the risk for being held liable for slanderous or libellous statements is concerned—it is enough to say that a physician who, in good faith, had reason to believe that the crime of producing an abortion had been committed, would be protected from any action for damages, if he communicated his suspicions to the proper authorities, even if it after turned out that the person against whom he had given evidence was not guilty of the suspected crime.

"It should be observed that such a communication (privileged communications) should be sensibly made. They must be honestly believed and the communication must be limited to those who have jurisdiction to entertain the complaint, or power to redress the grievance, or some duty or interest in connection with the matter. If the physician idly disseminated this suspicion, and it turned out to be false, he would then plainly and justly be liable to the individual whom he had carelessly slandered."

In cases of infanticide where the mother of the infant may claim ignorance of her pregnancy, I have knowledge of a recent case which would very strongly help to maintain this plea. I will illustrate: A woman of 42 years, married eighteen years, was having stomach trouble. She had been

treated for some form of stomach trouble for about seven or eight months, with no relief. On being examined about the eighth month of pregnancy, by another physician, she was found pregnant and told of her condition, with very great surprise to herself. So we see that it is possible for a woman to be ignorant of her pregnancy, though this, as we know, is a rare occurrence.

"We are expected, as before said, to give to our patients the benefit of our best judgment, although we do not render ourselves liable for a mere error of judgment. If, however, the latter is not consistent with reasonable care, skill and diligence, then we are liable. In action to recover damages for malpractice, the plaintiff may recover, although the physician was summoned and paid for by another. The husband of a woman who suffered death through unskilfulness in performing a surgical operation may recover damages from the surgeon for causing the death of his wife. Under some acts, a woman may sue alone for injury caused by malpractice."

The measure of damages may be arranged as follows:

"1. Loss of time or labor arising from injury sustained by malpractice.

"2. Reasonable expenses incurred for surgical, medical and other attendance in consequence thereof.

"3. Diminished capacity for work at the trade or business of the injured party in consequence thereof.

"4. Bodily pain and mental anguish in consequence thereof. Regard, also, should be made as to whether the injury be permanent or temporary and to the location of the injury."

"A physician or surgeon may be held criminally responsible for his malpractice, but only in case of the grossest ignorance or criminal inattention. If a medical man, through gross ignorance or inattention, cause the death of a patient, he is guilty of manslaughter.

"Then, to sum up the foregoing, the medical man is guilty of criminal malpractice:

1. When serious injury or damage results on account of his gross ignorance or neglect.
2. When he administers medicine or uses a surgical procedure in attempt to commit crime prohibited by statute.
3. When he wilfully or intentionally neglects to adopt such measures as may be required for the safety of his patient.
4. When he willfully or intentionally uses any medical or surgical procedure which is liable to endanger the life or health of his patient."

"A physician is civilly liable for any injury that may result which is traceable to his want of knowledge or negligence. He is expected to exercise an average amount of skill and care in the treatment of his cases, according to the locality in which he lives. If he exhibits these qualifications, he is not to be held accountable for results in the absence of an express contract to cure the patient."

"The fact of his having treated a patient gratuitously does not relieve a physician of his responsibility to furnish proper treatment, care and attention. He is not obliged to accept the treatment of a patient against his will; he cannot, however, withdraw without giving sufficient notice of his desire to do so."

"An action for malpractice cannot be brought against a physician after he has brought suit and obtained judgment for his services. He is relieved of all responsibility in connection with the treatment of his patient when the latter failed to follow or live up to the advice of the physician."

"A physician is civilly responsible when his assistants, through ignorance or carelessness, injure his patient, but he is not accountable for any wilful criminal act on their part. He is not responsible for any errors in judgment or mere mistakes in matters of doubt or uncertainty. He is not presumed to engage for any extraordinary skill or extraordinary attention and care."

A physician should always beware of compromising himself by a promise to cure the patient; if, however, he be so unwise as to make such a promise or contract, he will be held by the law to a strict performance of the same. In case of failure, it will be no defense for the physician to allege the occurrence of unforeseen conditions, neither may he allege insufficient skill or dexterity; these, he is supposed by the law to possess when he undertook the case.

It is *par excellence* for us in our practice to be at all times alert to our needs, and if we have a serious case, whether we feel competent or not, to have the counsel of one or more men in our own profession, of good standing, see the case with us and thus have added proof of performing our duty.

The fact of our services being gratuitous in any case does not affect our duty to exercise our best skill, care and diligence. As an illustration: If a physician should treat a patient for ten

months and abstain from making a claim for his treatment, particularly in a doubtful or balanced case, then it might be looked on as an admission of neglect or want of skill on his part in the treatment of the patient and would be one of the evidences against him. Therefore, if a physician has any idea that a suit for malpractice is being instituted against him, he should at once sue for the account, and do it before the patient begins his.

Here is something we should remember: "A recovery by a medical practitioner for his services will act as a barrier to any future action for malpractice, with some exceptions. In some states, however, it is held that if recovery be by confession or default it is not a bar."

There is one thing of which I wish to speak before closing and which diverges a little from the subject, but which should be considered along with it and that is—our relations to one another as coworkers in the same general line of work. We know that jealousy and selfishness too often enter into our work, and that because of this we are not charitable one to the other; I wish to say right here that this attitude does not pay. We would get along much better and live much happier if we did not allow the laity to misinterpret us, and if we would stand together and for one another, except in gross neglect or crime. We are supposed to be educated and intelligent beings, but if we are not broad enough to overlook the little things in others, which are not malicious, then I feel that our knowledge is lacking and we need a self-examination to see wherein we, ourselves, are at fault. I do not believe that any one of us is free from censure, and a self-examination would be profitable to us all.

How many of the laity would ever start a malpractice suit, or at least accomplish any result thereby, if we absolutely discouraged them when they come to us with their stories? We know that in most cases, as I have said, that every physician is doing his very best—according to his knowledge—for his patient, and that outside of those in the immediate family, there is no one more anxious to have the patient get well than the physician in attendance.

I hope that in this short outline I have brought something to your attention which will be of profit to you. I wish, also, to say that the information regarding these medical laws, or most of it, has been obtained from Dr. Justin Herold of New York, and all the honor is due him, for in many instances I have made exact copy of his work.

REPORT OF A CASE OF PUERPERAL SEPTICEMIA *

GERTRUDE M. JOHNSON, M.D.
BATTLE CREEK, MICH.

The patient, Mrs. I. L. P., an American woman, aged 36, came under my care Jan. 17, 1913.

History.—Her history is as follows: Mother living, has chronic stomach and bowel trouble. Father living and well. Three brothers all living and well. Aside from whooping cough and measles was in perfect health as child. Had Bell's palsy at 19, which left some permanent facial paralysis. Menstrual periods were regular and normal. Length of period one week. Married. With first pregnancy patient had a missed abortion, which was not diagnosed until some symptoms of septicemia had intervened. The uterus was emptied then. At that time the patient had some arthritic trouble. She had a birth four years ago with instrumental delivery, but normal puerperium, and on Dec. 12, 1912, a second birth with normal delivery. On the 14th the patient had a slight rise of temperature and very bad odor to lochia, and the following day, the fourth day of confinement, her physician used a dull curet and removed from the uterus a partly organized blood-clot, which he said was septic. A vaccine specialist was called in by her physician and they administered to the patient a stock vaccine for streptococcus. After two days of this, her temperature became normal. In the meantime an autogenous vaccine had been made from the uterine secretions and she was given an inoculation on the sixth day. She had no temperature then until the eighth day of confinement, when she began to have chills and her temperature ran between 103 F. and 104 F. Later she sweat profusely, and temperature fell gradually and was normal by morning. Patient had no rise of temperature then until January 3, when she had repeated chills, and temperature went to 105½ F. Began sweating after midnight and temperature was normal by morning. It remained normal then, except for slight reaction to vaccine on January 6, until January 11, when it was found 102 F. at 8 a. m. Chills later in the day brought temperature to 103 F. The next day temperature ran to 105½ F., and on the 14th, 106.4 F. Each day continued the same then, the height of temperature varying very slightly and coming up with chills and falling with sweats. Patient had a little hacking cough which she said she had had for about three weeks

* Read before Calhoun County Medical Society, May 6, 1913.

following a little cold she had taken. To the last two doses of vaccine there was no reaction, and her physicians, thinking surgical intervention was necessary, consented to her coming here.

Physical Examination.—On her arrival showed a woman of fairly good development, skin pale, tongue coated, pulse rapid (count 120) and irregular. Size of heart normal, a small murmur was heard at the apex and base, but was not constant, and because of condition of blood was judged as a haemic murmur. The lungs were negative. Splenic dullness extended from the sixth to the tenth rib. Liver dullness was normal. The abdomen was distended with gas. Lower border of the stomach was one inch below the umbilicus. There was tenderness over the right half of the abdomen, but particularly in the lower quadrant. Slight tenderness under the right rib margin. The uterus was found large and retrocessed, but not larger than would be expected so short a time after delivery. A dense hard mass was found in the right side of pelvis apparently lying behind the right iliac fascia.

Because of the patient's cough a fluoroscopic examination of the chest was made. An x-ray plate of abdomen was made to exclude any possible pus accumulations there. The report of the Roentgenologist, Dr. J. T. Case, was that x-ray studies show a marked collection of gas throughout the entire colon, also in the pelvis, but no evidence which could be interpreted as indicative of a pus collection.

The regular blood analysis showed a hemoglobin of 70 per cent., red cell count of 34 per cent., white cells 90 per cent. and blood-pressure 90. A differential blood-count showed no pathological cells present. The small lymphocytes were diminished by half, large mononuclears were diminished, eosinophils diminished and transitional forms increased. The red cells were of normal size. A blood culture was made. The smear for differential count showed the blood full of *Streptococcus pyogenes;* even large clumps of them were found. Urine analysis showed diminished quantity, low specific gravity, greatly diminished chlorids, urea 3.5 gm. for twenty-four hours and chlorids only .42 gm., a trace of albumin and urobilin present. Fecal analysis showed a mucous colitis present.

Patient entered the house about 3 a. m., her temperature was normal then and she was in profuse perspiration. Chill came at 1:30 p. m., and before 6 p. m. her temperature was 106. Patient was delirious and condition grave. She was seen in consultation by the chief surgeon, Dr. J. H. Kellogg, who decided that nothing could be done for the patient in a surgical way.

Treatment.—It was decided to give antistreptococcic serum, so 10 c.c. were introduced slowly. There was no unusual reaction, another dose was given in six hours. A third dose of 20 c.c. was given six hours later. A thermophore pack was kept on the bed and the minute there was the least sign of chilling she was wrapped in hot blankets, given hot drinks, etc. Cooling measures were applied during the fever and the ice-bag for the support of the heart was used systematically. Water was given systematically. The patient took practically no food, though the attempt to feed regularly was persisted in. One attempt was made to give saline infusion because of low blood-pressure—only 73—but pain was so great it was not persisted in. Water was also introduced by the drop method and by retaining enema into the bowels.

The serum treatment was kept up for five successive days, the patient receiving the first day 20 c.c., second day 60 c.c., third day 100 c.c., fourth day 160 c.c. and fifth day 120 c.c.—460 c.c. in all. On January 19—two days after coming—after consultation, she was given 9 c.c. of Bannerman's solution, intravenously, in the left median basilic vein. During the last two days when serum was given patient's heart was supported by strychnin. Up to this time patient's temperature followed the same course, the only noticeable change was that her chills were increasing in length of time they lasted and in severity. The patient was more delirious, vomited nearly always during the chills, was in a stupor part of the time and was generally weaker. In a differential count taken January 20, there were no bacteria found and none were found at any subsequent time, though several tests were made. At that time microcytes, macrocytes and poikilocytes were found, the size of red cells varied and morphology was given as irregular. The other features remained about the same. Urine showed granular and waxy casts that day, but otherwise it was same.

Subsequent Course.—The patient now began to have chills twice a day followed by the usual rise of temperature. The chills lasted sometimes forty-five minutes and were so severe as almost to shake the patient off the bed. In a few hours after height of fever temperature fell as low as 94.3 F. The pulse ran as high as 140 during fever. On the evening of February 2, it was noticed that patient's face was very puffy and spotted with purpuric-like spots. She complained of numbness and itching of the extremities and

there was extensive ecchymosis on the legs. She was unusually white around the mouth and pulse was weak and rapid. The spots were still on the face the next morning and the patient complained of pain and lameness in the right shoulder, had headache and was very despondent. On February 4 she broke out with urticaria over face and entire body. She had two chills that day, one lasting forty minutes and the other twenty-five minutes. Temperature was 105 F. later and patient vomiting during chill and delirious afterward. At this time the patient's food was averaging about 600 calories per day, most of which she retained. On the 6th she had a follicular pharyngitis, her arm was very bad and she said she felt as if all her bones would break if she moved. She was very restless. She was very stiff the next day, had pain when she moved and temperature was subnormal all day, but had chill at midnight lasting fifty minutes, vomiting. Heart was very weak. Gave her stimulants. On the 9th the patient began to have sharp pain in the right knee and leg. An examination of the heart showed its condition same as on entrance.

Examination of the pelvis on the 10th showed the thickening behind iliac fascia less dense and board-like. Hip and left leg began to pain that day. It will be noticed that about this time patient's temperature was not running quite so high, about 103 F. and 104 F. The next day her flesh hurt all over and she began to have such great pain in her feet that they could not be touched. Her feet and ankles were edematous. Pain began in the lumbar region and in both sacro-iliac synchondroses. It was very severe so that patient screamed for five or ten minutes at a time on slightest movement. She also had involuntary contractions of the muscles which would cause extreme pain so that she would awaken from sleep screaming. The temperature was very high again for a few days and the chills abated but little. Patient was hysterical part of the time from the pain. She lost her voice and could not speak above a whisper and her mind was bewildered. She was given large doses of aspirin every day, and codein and some morphin were used for relief in addition to hot packs. On the 23d the pain in the shoulders and knees was abating some, but it was so extreme in the right sacroiliac synchondrosis that it was thought advisable to examine her under gas. This was accordingly done, but no evidence of suppuration was found. The swelling behind the iliac fascia had practically disappeared, leaving only a hard small point of induration. The uterus and appendages were normal. There was no enlargement at the sacroiliac synchondrosis of either side. All joints were carefully examined and nothing abnormal was found. The conclusion was that there was no suppuration in any of the arthritic joints. She was greatly relaxed and relieved after anesthetic. The next day patient's temperature did not go above 100 F., and the following day, February 26, was the first twenty-four hours in about eleven weeks without chill or rise of temperature. The temperature continued normal after that time except for a slight rise one or two evenings when overtired. The pain gradually disappeared from joints following the course of its appearance, shoulders first and back last. Appetite improved rapidly, on March 2 patient ate over 2,000 calories of food, and in a week more was eating 3,000 calories.

For two weeks she continued very nervous and restless and peevish. During the extreme pain in her back she could not be moved, and the heat and moisture and pressure contributed to a sudaminal eruption that covered the back, and to two small bed sores, one of which healed in a few days, the other had become infected and developed a superficial abscess over the left sacro-iliac synchondrosis. This was lanced by the assistant surgeon, Dr. Harris, and drained and healed in a normal way. There was a question brought up as to whether, since it lay immediately above the joint, that was so painful, it did not come from the joint so the wound was filled with Beck's paste and an x-ray again taken by Dr. Case. It proved conclusively that the joint was not involved.

April 13 a red spot was noticed on the arm at the point of injection of the median basilic vein with Bannerman's solution. In two days an abscess had developed there and was opened, evacuating more than a teaspoonful of pus. Induration extended upward along the vein for an inch and a half. The wound healed rapidly. The patient improved rapidly under hydrotherapy, massage and joint movements. She gained in weight, bowels moved normally twice a day, urine cleared up, pulse grew slower, murmurs disappeared from the heart, blood-count improved and patient gained daily in strength. She was allowed to go home April 27. For a week previous to that time she had been able to walk unaided the length of the halls and back, and had played the organ, pumping it herself. She had occasional little pains in the joints on damp days, but I considered her convalescence far enough advanced to allow of her going home with perfect safety.

A SERIES OF CLINICAL CASE REPORTS

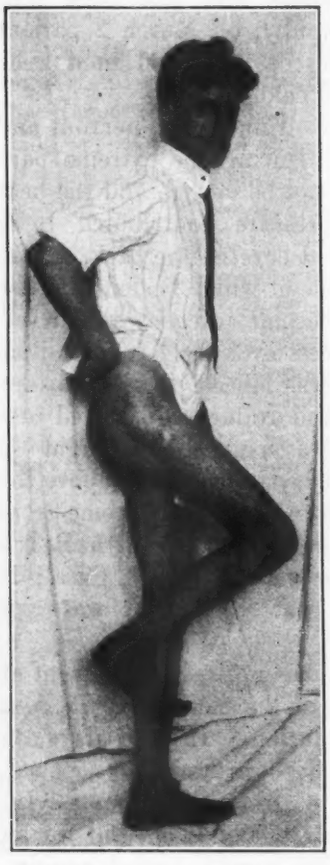
H. N. TORREY, A.M., M.D.
DETROIT

ANKYLOSIS OF HIP ARTHROPLASTY

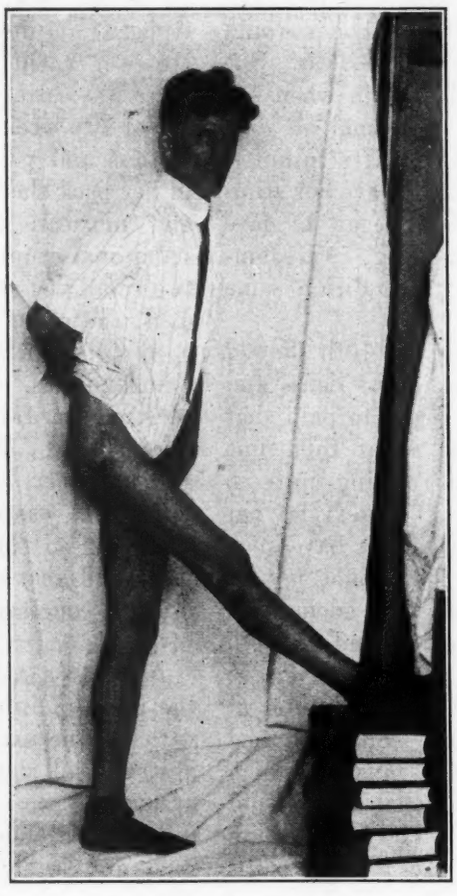
The patient, a male, 31 years of age, was referred to me June 24, 1912, by Dr. W. F. Metcalf of Detroit.

History.—The history is as follows: Family history, no tuberculosis. Past history, childhood diseases with no sequelae; no typhoid, pneumonia, scarlet fever or diphtheria. The patient during childhood remembered having had many "sore throats," but with no complications. At the age of fifteen (in 1896), he was severely ill for three months with "inflammatory rheumatism." At that time he had a high fever and all the joints were red, swollen and very painful. He suffered no ill effects following this attack. Similar but milder attacks followed at intervals of from six to eight months, until 1903. In the Fall of this year the patient was taken suddenly ill with a chill followed by fever, and an inflammatory involvement of all the joints of the upper and lower extremities. After one month the infection was localized in the right hip. There was exquisite pain upon any motion of the hip joint, and the only relief obtained was by drugs and by flexing the thigh on the abdomen. The swelling was slight and there was no redness. The treatment was the customary medical one, and extension was not applied. He recovered after an illness of six months with the hip in the present condition.

Physical Examination.—A man fairly well nourished, with normal heart and no lung changes. He walked with difficulty in a stooped position, using a cane, and with the right shoe built up ten inches. The right thigh was flexed at an angle of 45 degrees and the hip was immovable. The skiagram showed a bony ankylosis. The knee could not be extended completely, because of contraction of the flexors. (This history is a typical one of metastatic arthritis following tonsillitis. The treatment, judged from present-day standards, was not efficient, as the application of extension would have relieved the pain and the deformity, and probably prevented the ankylosis.)



1. Arthroplasty of hip. Photograph taken May 24, '13, to show condition previous to operation.



3. Arthroplasty of Hip.

2. Arthroplasty of Hip.

Operation.—Sept. 7, 1912.—Arthroplasty following the technic as outlined by Dr. J. B. Murphy of Chicago. A U-shaped incision was made through the skin over the great trochanter, and a similar but larger flap was fashioned from the subcutaneous fat and fascia lata. The joint was exposed by sawing off the great trochanter,

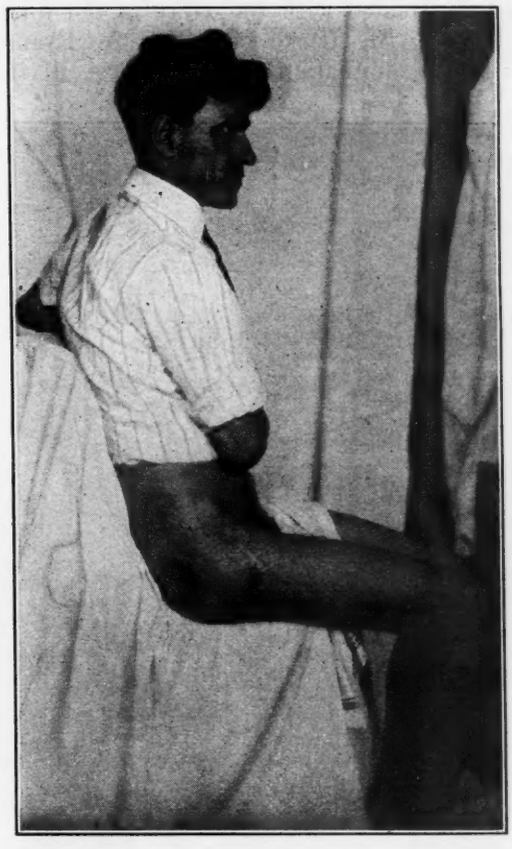
and the capsule was freed from the neck of the femur, leaving its attachment to the acetabular margin intact. The head of the femur was then chiseled free from the ilium. In doing this, a portion of the head was broken from the neck. The head and socket were prepared by means of the Murphy end mill and reamer, and after suturing the capsule and pedicled fascia lata flap in position in the acetabular cavity, the femoral head was replaced. The trochanter was nailed in position and the transfixed muscles repaired. The wound was closed in the regular manner and dressed in a voluminous 5 per cent. carbolic acid dressing. The patient was placed in a dorsal position and double abduction was maintained by the Rainey modification of the Travois splint. Buck's extension was applied. There was some

4. Arthroplasty tabes.

shock following the operation, but the general condition was good after eight hours. Except for a sloughing of a small portion of the distal end of the skin flap, there were no further complications and the patient was about on crutches in the fifth week. He had fairly good motion in the hip at this time and practically no pain. He was discharged from the hospital Oct. 26, 1912. When seen in November, 1912, he was in good health and had every motion of the hip, though not yet in a normal degree. Extension of the thigh was still limited by the contracted abductors. (This condition, I am sure, will be remedied by the proper exercise and massage.) May 24, 1913, there was one-half inch shortening of the right leg. The patient stood in an erect position and walked well. The movements in the hip, while not yet normal, were increasing gradually in degree. The patient attended daily to his work as "store keeper" in an automobile factory, and was freed from his previous handicap. The photographs were taken May 24, 1913.

RHINOPLASTY

This case contains nothing new in the matter of technic and is reported because of its general interest. The patient, a male, 45 years of age, was referred to me by Drs. A. P. Biddle and A. R. Wollenberg of Detroit, with a diagnosis of epithelioma of the nose and the upper lip.



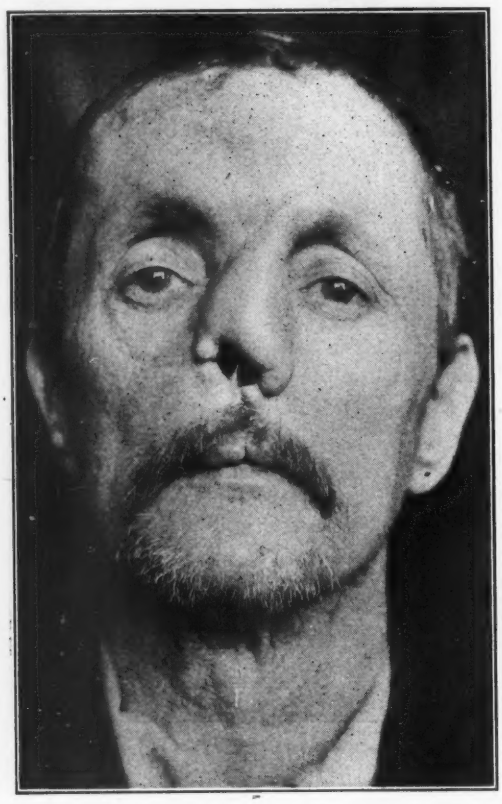
5. Arthroplasty of Hip.

History.—The history, in brief, is as follows: Family history and past history were not important. Present illness began two years ago, with a small skin lesion on the nose. The growth gradually extended, involving the soft parts of the nose and the adjacent portion of both cheeks. The lesion was excised one year ago, but recurred in four months and since this time it had extended rapidly. Physical examination showed an ulcerating, infiltrating growth, involving the soft parts of the nose, nasal mucosa over septum and the median portion of the upper lip. Wassermann test negative. No cervical glands enlarged. Tissue excised for diagnostic purposes showed squamous cell carcinoma.

Operation.—On Oct. 29, 1912, I made a dissection of the submental and submaxillary glands of both sides of the neck. At the same time a

wide excision of the growth was made, removing all the soft tissues of the nose and the nasal cartilages, together with the anterior portion of the septum and a major portion of the upper lip. The lateral portions of the upper lip were freed from their bone attachments and sutured together in the median line. Rubber tubes were inserted into the anterior nares. The patient made a rapid and uneventful recovery from this operation. The lymphatic glands showed no signs of metastasis.

Post-Operative Course.—On Dec. 12, 1912, the patient presented himself for plastic work. He had been treated with the x-ray in the interval by Drs. P. M. Hickey and W. A. Evans of Detroit. Examination showed a large pyriform



Rhinoplasty. Photograph taken April 15, 1913. Result obtained.

opening in the absence of the nose, which gave the patient a very repellant appearance. There was no evidence of recurrence of the growth. The lip showed a median line scar, otherwise normal.

Plastic Operation.—Rhinoplasty by the Indian method. The skin edges of the nasal defect were freshened and a flap from the forehead was turned down and its edges sutured to those about the opening. This gave an epithelial lining for the new nose and placed the raw surface of the flap outward. A second and much larger flap was cut from the forehead in an oblique manner so that its pedicle included the left angular artery. The lateral edges of this flap were folded together laterally to form the alae of the new nose and its median portion was molded to form the septum. It was then sutured in place to the underlying flap (the raw surfaces being together) and to the adjacent skin edges. The defect in the forehead was lessened by suturing the surrounding tissue together and by sliding skin flaps upward from the area between the eyes. The newly-formed nasal openings were kept open by rubber tubes and a wire gauze mask was placed over the face. The patient made a rapid recovery and all the wounds healed by first intention.

On Jan. 3, 1913, the defect in the forehead was covered with skin grafts and a wire gauze mask was placed over the wound. The patient left the hospital Jan. 22, 1913, in good condition. The forehead wound still showed areas of granulation and the skin grafts were gradually extending.

I had planned to do further work on this case, but the patient refused, being well satisfied with his present nose. The retraction upward of the left side could easily be remedied and would give the patient a very good cosmetic result. I had further considered supporting the nose by a framework of costal cartilage placed in a tunnel between the two epithelial layers, but this was unnecessary. The patient was last seen on May 20, 1913, and there was no recurrence of the epithelioma.

CARCINOMA OF THE THYROID GLAND

Carcinoma of the thyroid gland is by no means as infrequent as one would think in looking over the literature on the subject. On the contrary, malignant diseases of this gland are not rare, as can be seen from the reports of the Mayo Clinic, in which eighteen cases of carcinoma were found in 1,000 operations for goiter, and nine were refused operation.

I wish to report two cases, one with extension and metastasis in a woman 58 years of age, the other in a young woman of 24 years. In the first case the diagnosis was made at the physical examination. The condition was inoperable, and the diagnosis was confirmed at autopsy. The second case was an especially instructive one, a growth of the thyroid occurring in a young woman and giving no sign or symptom of its malignant nature. The diagnosis was unsuspected and was made from the specimen removed at operation. There has been no recurrence in seventeen months, and the patient is in the best of health. I report these cases because they effectively illustrate the following very important points: First, that carcinoma of the thyroid is amenable to surgical treatment only when diagnosed early; second, the question of malignant degeneration must be considered in all cases of

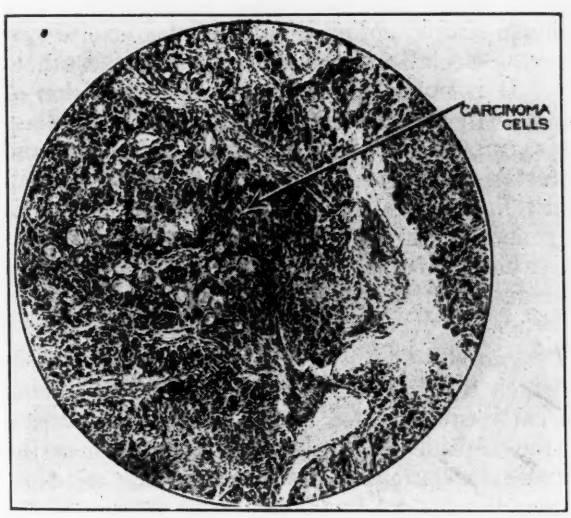
goiter after puberty, especially in those cases where there is a sudden and rapid increase in the growth of the goiter.

CASE 1.—Mrs. M. B., aged 58 years, a patient of Dr. G. E. McKean, seen at Harper Hospital, Nov. 26, 1907. History, no carcinoma or goiter in the family. Personal history was not important.

Present Illness.—Patient has had an enlargement of the thyroid without symptoms for ten years. Four months ago, she had pain in the goiter and it enlarged rapidly. As the growth increased, she experienced severe pain, great difficulty in swallowing and marked dyspnea. The increase in size had not been so apparent during the last month, but she noticed the mass was becoming hard and nodular.

Physical Examination.—Physical examination showed an emaciated woman, with marked dyspnea and dysphagia. A hard, nodular, diffuse mass in the lower and anterior portion of the neck; dullness on percussion over the upper third of the sternum.

The patient died ten hours later.



Carcinoma of Thyroid. Area of diffuse infiltration.

Autopsy.—Autopsy revealed a nodular, infiltrating growth of stony hardness, involving the left lobe of the thyroid gland, trachea and esophagus, together with the muscles of the neck. The primary growth occurred in the left lobe of the gland, and breaking through the capsule invaded the surrounding tissues. A section showed a structure of firm, fibrous tissue with occasional alveoli, containing nests of epithelial cells. Metastasis had occurred in the mediastinal lymph glands and in the lungs, but none in the bones.

Diagnosis.—Scirrhous carcinoma of the thyroid gland with metastasis in the mediastinal lymph glands and lungs.

CASE 2.—Mrs. W. B., aged 24 years, consulted me Dec. 28, 1911, complaining of a mass in the neck and hoarseness.

Family History.—Two uncles died of pulmonary tuberculosis. An aunt and cousin have goiters.

Past History.—Childhood diseases with no sequelae; negative history of infectious diseases. Patient had chorea at the age of 10, and at the age of 15 had a lung condition which was diagnosed as "consumption." Since that illness she has had bronchitis every winter; no night sweats, no loss of weight; tubercle bacilli were never found in her sputum. Marital history, two children (5 and 3 years), alive and well. Patient had one miscarriage in 1910, followed by sepsis. Her menstrual history was normal.

Present Illness.—The patient noticed a small goiter (left side near median line) in 1906, following her first pregnancy. The enlargement

Carcinoma of Thyroid. Case No. 2. Photograph taken 17 months after operation—note absence of scar.

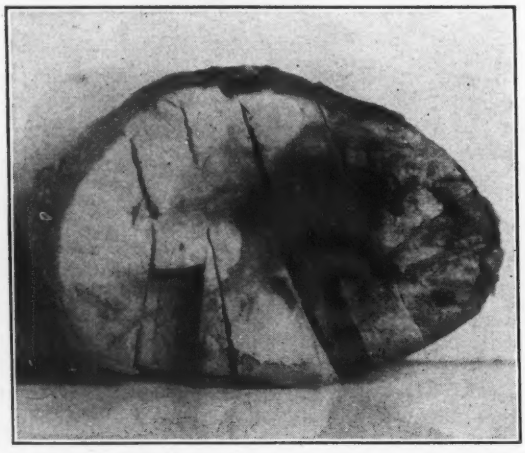
increased in size until at her second confinement (in 1908) it was the size of a "hickory nut." It remained the same, causing no symptoms until August, 1911, and since this time had gradually increased in size. There had been no pain, no difficulty in swallowing and no choking. The only symptom that she noticed was slight hoarseness, which came on at intervals.

Physical Examination.—Physical examination showed a thin, anemic woman with no signs of hypothyroidism or hyperthyroidism. A firm oval mass involved the left lobe of the thyroid; no fluctuation, freely movable; no nodules. The mass measured 8x6x5 cm. (approximately). No lymph glands were palpable. Larynx: congestion of vocal cords, no paralysis. Lungs showed no pathological changes.

Diagnosis.—A diagnosis was made of adenoma of the thyroid and its excision advised.

Operation.—Jan. 22, 1912; operation at Harper Hospital. The left lobe containing the growth, together with the isthmus, were excised. The increased vascular supply of this lobe made me suspect that the condition was not an adenoma. There were no adhesions and the gland was easily shelled out of its capsule. The right lobe was normal; no lymph glands were enlarged.

Post-Operative Course.—The patient made a rapid and uneventful recovery, leaving the hospital Jan. 31, 1913. The hoarseness cleared up in a month and the patient has resumed her vocation as a singer. May 29, 1913, the patient was in the best of health; no return of symptoms and no recurrence. She is at present the soprano of one of the local churches.



Carcinoma of Thyroid. Case No. 2. Section through neoplasm.

Pathological Report.—Pathological report by Dr. J. Sill, Pathologist of Harper Hospital: tumor of the thyroid, regular, oval, 9x7x5 cm. Its surface is grayish, mottled with red. On section, it is homogeneous in texture, gray in color, mottled with dark areas. The microscopical picture is that of an adenoma of the fetal type with some secondary fibrosis. The cells, however, are markedly atypical in their general appearance and staining reaction. In many fields there is a marked tendency to infiltrate the surrounding tissues.

Diagnosis.—Carcinoma of the thyroid gland (beginning in a fetal adenoma).

Pathology.—In general, the epithelial neoplasms of the thyroid gland may be divided into three classes: (1) the ordinary alveolar type, (2) the scirrhous and (3) the adeno-carcinoma. The latter type is especially interesting in that neither the growth nor the secondary tumor depart histologically from the normal gland structure. Kocher, however, gives the following classification: (1) Genuine carcinoma of the thyroid, the most frequent of the epithelial growths, produced by a proliferation of the epithelial cells of the follicle; (2) proliferating goiter, consisting of solid masses of epithelial cells arranged at the periphery of the lobules and uniting toward the center to form tubes and follicles; (3) metastatic colloid goiter; (4) papilloma; (5) cancroid squamous epithelial cancer; (6) glycogen containing epithelial goiter; (7) small alveolar epithelial goiter.

Etiology.—The majority of carcinomata of the thyroid gland follow the benign goiter. Halstead reports a case which shows a direct relation between trauma and the malignant condition. Pregnancy influences the development of cancer only indirectly through the simple goiter. Eberhardt, Müller and Speese (quoted by Halstead) report the disease more frequent in the female than in the male (60 per cent. female, and 40 per cent. male). While the disease is by no means uncommon before the age of 35, the majority of cases are between the ages of 35 and 50 years.

Signs and Symptoms.—Carcinoma in the early stages may be impossible to diagnose. Rapid growth, pain and symptoms of pressure in a hitherto simple goiter should at once excite suspicion, especially if the patient is in the cancer age. It is much better to advise the excision of the growth at once than to wait until the diagnosis can be definitely made. Extension and metastasis mean malignancy, but they also mean that it is too late for a radical cure. Metastasis is generally through the blood-vessels and involves most frequently the lungs, next the bones, liver and pleurae, the lymph glands more rarely (Kocher).

Prognosis.—Cures are only reported in cases in which the disease was radically excised during the early encapsulated stage. After the invasion of the capsule or the surrounding tissues the chances for cure are practically *nil.*

PRIMARY TUBERCULOSIS OF THE BREAST

Tuberculosis of the breast as a secondary lesion is of no special interest, whereas the primary involvement of this gland by the tubercle bacillus possesses much of interest and practical importance. The fact that this disease, especially in its early stages, is invariably confused with malignant lesions, and in its later stages other organs may be involved, shows the importance of the diagnosis and treatment of this condition.

Occurrence.—A search through the literature is rather unsatisfactory, because many cases are reported without full details, and it is impossible to differentiate the primary from the secondary types. Anspach[1] (1904) analyzed Bartsch's[2] series and found thirty authentic cases of pri-

1. Anspach: American Journal of Medical Sciences, cxx, 8, July 1904.
2. Bartsch: Inaugural Dissertation, Jena, 1901.

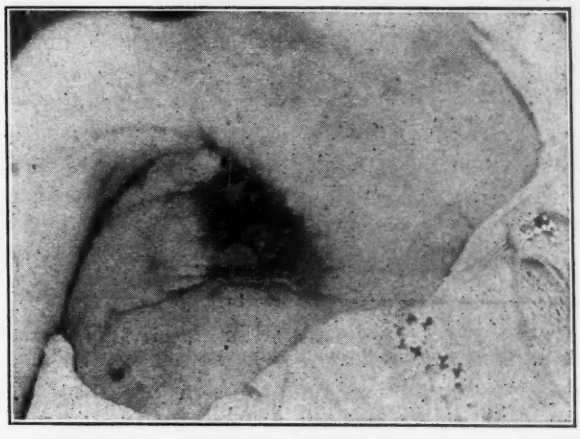
mary involvement of the gland. To these, Anspach added twelve. Schley[3] mentioned twenty more (though he does not differentiate between the primary and secondary lesions), bringing the literature up to 1910. Powers,[4] in 1913, reported one personal case of primary involvement and noted two from the Mayo Clinic[5] (in a series of 1,000 breast conditions). The five cases observed by Mantelli[6] and quoted by Powers were probably not all of the primary type.

Etiology and Infection.—Heredity is not a causative factor, and trauma plays an insignificant part in the etiology of this disease. Direct infection has been reported in several cases. The consensus of opinion is that the route of infection is through the blood and lymph vessels (mainly through the former) and that the site of infection is an abrasion at the nipple or in the skin of the gland. The disease is most common between the ages of 20 and 30 years. The female breast is practically always involved, generally when the gland is active. The cases of tuberculosis of the male breast are few (reported by Poirier,[7] Delbet,[8] Bartsch[2] and Parsons[9]).

Pathology.—The disease (both primary and secondary) shows itself in two forms: (1) the nodular or the discrete and (2) the confluent. In the first form the nodules may be single or multiple. They may remain stationary for a long period, but as a rule degenerate and form cold abscesses. The breast is seldom enlarged or deformed. The confluent type, on the contrary, degenerates and forms fistulae early and usually enlarges and deforms the breast. There are various stages between these two forms. The case which I report, while belonging to the discrete type, showed a general fibrous structure with nodules not unlike, in gross appearance, the scirrhous carcinoma. The axillary glands are involved in about 75 per cent. of the cases.

Diagnosis.—As a rule, the absence of signs or symptoms in the nodular type is such that the disease is fairly well developed before it is recognized. The confluent form, however, shows itself by the early enlargement of the breast and by pain. In general, it may be said that the diagnosis of the disease is very difficult in the early stages, and that it cannot be differentiated by signs and symptoms from other breast conditions, especially those of a malignant nature. In this connection, however, it is important to bear in mind the following points: Tuberculosis of the breast occurs at any early age (20 to 30); the patient generally has a tubercular history or may have other tubercular foci; the tuberculin reaction is positive; the growth very seldom retracts the nipple or is adherent to the muscles or skin; the growth is slow and generally painless; fluctuation or sinuses may be present; the axillary glands are usually involved early. With all this data there are many cases which cannot be differentiated from those with malignant conditions. In this event tissue should be excised and studied carefully in the laboratory. My experience with the quick-frozen sections in border line cases (the really important ones) has been very unsatisfactory.

Treatment.—Excision of the growth with little mutilation of the breast, followed by tuberculin treatment has given good results. Curetting or cauterizing the sinuses, excision or aspiration of the abscesses and other palliative measures have been done and the patients have been cured. In general, I am inclined to believe with Powers when he says that the classical operation must be the thorough removal of the breast, pectoral fascia and axillary contents. The dissection need not, however, be quite as radical as that used in the malignant diseases of this gland. Exceptional cases may be treated less radically, but they should be watched carefully, bearing in mind the danger of extension of the disease. The prognosis is good following the amputation of the breast and the removal of the contents of the axilla. Braendle (quoted by Powers) gives 92 per cent. of cures following radical measures. Excision of the growth only may mean another operation and may also give a bad prognosis.



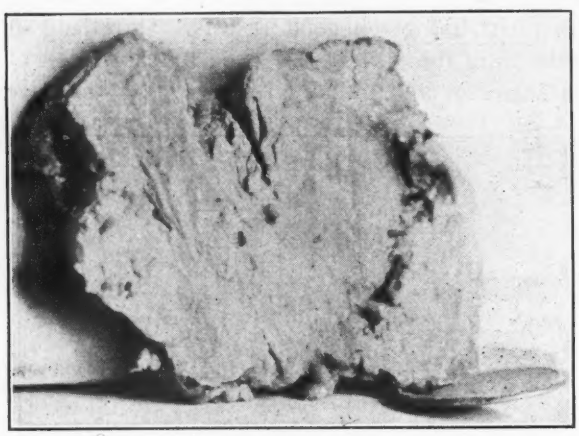
Cut No. 1. Tuberculosis of Mammae. Photograph taken following operation—shows skin grafts extending.

Admitting that "no case can be complete without an autopsy," I feel justified in recording this case as one of primary tuberculosis of the mammary glands on the following points: (1) the

3. Schley: St. Luke's Hospital Reports, 1910, ii.
4. Powers: Annals of Surgery, lviii, No. 2.
5. Wilson, L. B.: Personal communication to Powers.
6. Mantelli: Morgagni, Part 1, page 98.
7. Poirier: Archives Generales de Medicine, v, Edit. 1.
8. Delbet: Traité de Chiurgie, v, Edit. 1.
9. Parsons: British Medical Journal, 1907, No. 2431.

absence of a tubercular family or personal history; (2) the failure to find other foci of tuberculosis in the body; (3) the absence of tubercles in the axillary glands; (4) the pathological picture.

History.—The patient, a married woman, age 27 years, consulted me Jan. 24, 1913, regarding a mass in her right breast. Family history; no tuberculosis. Past history: always healthy; childhood diseases with no sequelae, negative history of infectious diseases. Marital history: four children (ages 7, 5, 3 years and 6 months), alive and well. All were breast fed except the last child, whom she weaned in December, 1912, because the child was not doing well on the breast milk. Menstrual history: normal, except for irregularity since November, 1912.

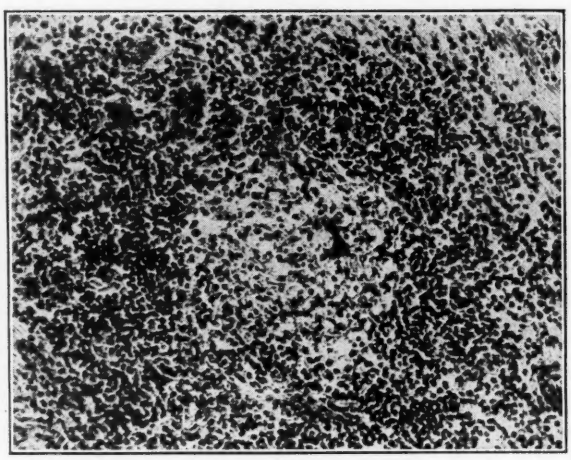


Cut No. 2.—Tuberculosis of the breast. Photograph shows cross section through amputated breast.

Present Illness.—The patient's attention was drawn to her right breast one week ago because of a bite inflicted by her husband when he was delirious. She noticed at the time several nodules in the breast. There was no pain or tenderness and she had no knowledge how long the condition had been present. The gland was not active, though it had been so Jan. 15, 1912.

Physical Examination.—Fairly well nourished woman with anemic pallor of the skin. Temperature normal. Lungs: careful examination showed no changes. Heart normal. Mammary glands: left normal, no nodules, no secretion from the nipple. Right, not active, no secretion from the nipple. The inner hemisphere and the lower and outer quadrant were involved by a diffuse infiltration with numerous ill-defined nodules (varying in size from a pea to a hickory nut). The condition resembled very much to palpation the "caked" breast of lactation. There was no redness or tenderness and no evidence of cyst or sinus formation. The nipple was not retracted. The mass was very diffuse and seemed attached to the skin, but the nodules were freely movable. The pectoral muscles were not involved. Palpation showed a little enlargement of one of the axillary glands. Very careful examination of the entire body was made, and no further foci of disease were found. A tentative diagnosis of malignancy was made, though the possibility of tuberculosis was considered.

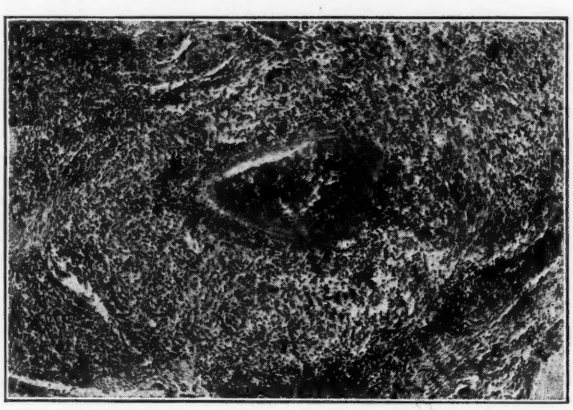
Operation.—Harper Hospital, Jan. 25, 1913. A nodule was excised and a frozen section was made.



Cut No. 3.—Tuberculosis of Breast. Young tubercle in center of acinus, surrounded by diffuse round cell infiltration.

Pathological Report.—A neoplasm (not carcinoma), the nature of which could not be determined from the tissue section, but one which was probably malignant. Macroscopically, the neoplasm was not carcinoma, but resembled very closely sarcoma. There was no caseation necrosis or any other gross evidences of tuberculosis.

From these findings I decided to remove the breast and the axillary contents. The gland was



Cut No. 4.—Tuberculosis of Breast. Old tubercle with broad epithelial zone and small caseating center.

removed together with a wide margin of skin. The pectoralis fascia being adherent to the growth, the pectoralis major was excised and the pectoralis minor was cut from its costal attachments and sutured in place over the axillary contents, thus acting as a pad and preventing scar pressure on the vessels. The axilla was dissected clean; only two glands were enlarged.

Owing to the wide excision of skin I was unable to cover all raw surfaces with flaps and decided to cover the remaining area (6x8 cm.) with skin grafts at a later date. The patient made a good recovery.

Pathological Report.—By Dr. J. Sill (Pathologist of Harper Hospital): The breast contains a large ill-defined, diffuse tumor in many areas involving the skin. The growth is pinkish gray in color, streaked with white bands of hyaline connective tissue. Microscopical sections show a diffuse inflammation of a granulomatous type superimposed on a rapidly growing adenoma. About the lobules of inflamed glandular tissue the connective tissue has become densely hyaline giving an appearance of an attempt to wall off each lobule. All the active tubercles were found within the lobule and not in the connective tissue. The larger ducts are here and there filled with caseous material containing degenerating polymorphonuclear cells. The striking characteristic of the larger tubercle is the small caseating center surrounded by a very broad epithelioid zone. The axillary glands show no evidence of tuberculosis.

March 24, 1913. The granulating surface was covered with Thiersch skin grafts. May 28, 1913, small areas of granulation were still present in the wound. The grafts practically all held, but have extended very slowly. The patient is in good health and there is no evidence of any tubercular lesion in the body. The patient is being treated with tuberculin by Dr. H. S. King of Detroit.

505-7 Shurly Building.

CLINICAL CASE REPORT OF FRACTURED VERTEBRAE *

F. C. KINSEY, A.M., M.D.
GRAND RAPIDS, MICH.

On the night of Feb. 18, 1913, a Syrian, employed at common labor, fell with a freight elevator about forty feet down the elevator shaft. A heavy truck was lying across his body when he was found, and this is undoubtedly what broke his back. He was taken to Butterworth Hospital in the police ambulance. Aside from the fracture of three metatarsal bones of the right foot, he had received no other injury except that to his spine. At the level of the twelfth dorsal and first lumbar vertebrae could be felt an angular prominence which protruded about an inch from the surrounding surface. Above this prominence sensation was normal, at its level hyperesthesia was present, and below this area paresthesia, gradually diminishing—after about two inches—into anesthesia of the lower trunk and limbs. He felt no pain from his broken foot and had no sensory perception of pins stuck into his legs and back below the injury. During the examination he seemed to suffer no pain except when his back was moved, on which occasion he emitted blood-curdling yells in a high tenor, Caruso-like voice.

The patient's anesthesia was evidently produced by pressure of a dislocated twelfth dorsal vertebra, along with a crushing of the twelfth dorsal and first lumbar vertebrae. To give him some immediate relief from this pressure, if possible, I determined to try an experiment in spinal manipulation—and to this, I believe, the man primarily owes his life.

He was suspended from a jury-mast by slings under his head and arms, thus causing the weight of his body to widen the intervertebral spaces as much as possible. Then, while several assistants steadied the body, an attempt was made to reduce the dislocation by pressure. It was conceded by those present that the prominence, while still palpable, was noticeably flatter. More important, however, was the fact that sensation had been restored anteriorly, showing that there was a diminution in pressure. While still suspended in his slings, the patient was encased in a thick plaster-of-Paris cast and taken to the ward.

From the time of the injury he had involuntary and unconscious bowel movements in bed. His knee-jerk was exaggerated and the cremasteric reflex was absent, together with ankle clonus. He had no ability to extend the leg, although he could flex it slightly through the action of the psoas and iliacus muscles. There was no tenderness or feeling in the testicle on pressure.

The man's symptoms persisted with what seemed a slow retrogression for nine days, when the pictures which Dr. Hulst will show to-night were taken, demonstrating a crushing of the twelfth dorsal and first lumbar vertebrae. No improvement in symptoms occurring, the patient was operated on May 1, ten days after his injury; Drs. Dubois and Collisi assisting.

Operation.—Cutting down over the involved area, the spinous processes, the laminae and the transverse processes of the twelfth dorsal and first lumbar vertebrae were removed with a rongeur forceps, thus exposing the spinal cord in its dura. Fragments of bone were found impinging on the dura and producing edema, but as no hemorrhage into the cord or pus formation could be found, the dura was left unopened. After clearing out the fragments of bone, the muscles were drawn

* Reported before Kent County Medical Society, May 28, 1913.

together, leaving a small wick drain, which was removed two days later.

Result.—There was no elevation of temperature and the patient recovered perfectly from the operation. The area of anesthesia, marked with ink on the posterior aspect of the man's lower extremities, receded in a remarkable manner—moving inward about an inch each day. The involuntary defecation and micturition continued for several weeks, but finally full control of the rectum was established and nearly perfect mastery of the bladder sphincter. The company for whom he worked have been very kind to him, purchasing, among other things, the ambulatory apparatus which I have brought down to-night. This was of great assistance to the patient at first in re-learning to walk, but he has now outgrown it and uses it very little. Aside from an involuntary dribbling when he first gets on his feet, and the natural weakness following so serious an accident, his spinal cord symptoms have practically disappeared. At present, while not very sure of himself as yet, the man is able to walk across the room unassisted.

ST. MARY'S HOSPITAL, DETROIT, STAFF CLINIC; CASE REPORTS

The regular staff clinic of St. Mary's Hospital was held in the hospital amphitheater, Wednesday evening, March 12, 1913. Dr. F. W. Robbins presided, and presented the first case as follows:

Gentlemen: It should happen only once in a long time that one should report a stricture of the urethra through which the surgeon cannot pass a bougie after long, careful and repeated attempts. It has been my misfortune, however, to have operated on three such cases within the past month.

The first of these was a patient who, through neglect, was first seen with extravasation of urine. The scrotum was much swollen, the penis was nearly as large as one's forearm and pus and urine had collected in the inguinal canal and infiltrated the tissues above the pubis.

A perineal incision was made, the finger passed up along the cord, opening up the infiltrated area and the strictured urethra incised. As a result the swelling gradually subsided and now we are passing No. 26 sounds through the urethra at intervals of five days.

The two other cases which I present to you were both operated last week. These cases were unlike the first and quite different from each other, and treated as I will now explain to you.

One of these cases is that of a negro on whom a perineal section was made a year ago. Below the scrotum was a hard mass extending from the urethra to the skin. This mass was as large as a small egg and surrounded a very small fistula. This was probably caused by an attempt on the part of Nature to close the fistula, which it seems she could not do. After making an elliptical incision around the small opening, I dissected out the entire mass down to the urethra, and incising it, I was able to pass a good-sized sound from the meatus into the bladder. It is our intention to keep this canal open with sounds until the perineal wound has closed and then insist that sounds be passed at longer intervals for an indefinite length of time.

The second case came into the hospital with a greatly distended bladder which we could relieve only by suprapubic puncture. After draining the bladder for several days by means of a catheter in the suprapubic wound and several attempts to pass bougies of various sizes, he was placed on the table, a sound passed through the bladder wound into the urethra and pressed against the proximal face of the stricture. The two ends of the sounds were then about a half inch apart, a perineal opening was made and the urethra incised between the ends of the two sounds. In this case there was no infiltrated mass to remove—a sound was easily passed—a number thirty. We expect, with attention to systematic soundings, to bring to this man good health.

By referring to the first case in which infiltration of urine had taken place, I desire to emphasize the necessity, in all such cases, of early operation. In one other case seen recently and in this one, life was undoubtedly saved by prompt operation. Two similar cases I have seen in consultation and operated, but too late to save life.

My first case shown to-night is an example of the ease with which some infiltrated masses may be dissected out. In connection with my last case I would suggest that in cases with retention due to strictures which cannot be passed with any catheter or bougie, the part of wisdom is, instead of puncturing the bladder with a small trocar, to pass a large cannula through which a rubber catheter may be passed and the cannula then withdrawn. In case this is done by means of retrograde catheterization, a later perineal urethrotomy will be made much easier.

Dr. Edward W. Mooney exhibited the next case.

This patient, a widow, 35 years of age, now convalescent, came to the hospital because of in-

tense, continuous, epigastric pain, which was increased by taking food and which was so severe that rest or sleep was out of the question. She was nauseated and frequently vomited small quantities of mucus; no blood was seen, nor could any history of hematemesis be obtained. Exhaustion was plainly evident; the epigastrium was tender and pressure near the region of the tenth dorsal vertebra on the left side caused pain.

Because of the irritability of the stomach, the increased pain caused by food and the possible danger of perforation or hemorrhage, no effort was made to give a test-meal to obtain the stomach contents for analysis. The bowel seemed empty, repeated washing with enemas gave no result, so we could not examine the stool for occult blood.

A diagnosis of gastric ulcer was made, the patient put to bed and given ¼ grain of morphin sulphate subcutaneously every three hours until the pain was relieved. Cracked ice was allowed to be eaten, but no food or drink was given by mouth. Each morning and night, after a cleansing enema had been given, the patient received four ounces of peptonized milk per rectum. For seventeen days she has had neither food nor drink per mouth, excepting, of course, the cracked ice. Improvement has been rapid, and the last few days the patient has been begging for food. Yesterday we started her on buttermilk, which she handled very nicely; this morning she received a bismuth and buttermilk breakfast, and the x-ray pictures taken by Dr. George C. Chene, show a marked ptosis, the upper border of the stomach being well below the navel, the lower border near the symphysis. We also found evidence of dilatation. The site of the ulcer is on the lower border, near the pylorus.

As far as present needs are concerned, the patient is practically well; she will go home tomorrow, with instructions as to diet and she will be given tonic medication to overcome the anemia and exhaustion resulting from her illness.

But what of the future? This attack is but one of many that have occurred in the past few years, and it is more than probable that she will have a return of the trouble. We will, therefore, advise her to return to the hospital when she is in good physical condition and to submit to the necessary surgical procedures to correct the ptosis and to remove the ulcer area if necessary, hoping, thereby, to escape the hopeless condition of cancer of the stomach which looms large ahead.

Dr. E. H. Sichler then presented the following case:

J. G., age 19, who entered the medical ward March 3, 1913. Occupation, laborer. Family history negative; personal history negative, with the exception that one year ago he suffered with an illness similar to that which he now presents. This previous illness lasted two months, after which he returned to work in normal health with the exception of a slight, persistent pain in the knee and ankle joints. This eventually disappeared. One month ago the patient suffered the second attack. This began with a sore throat, chill, rise of temperature, painful, swollen knee and elbow joints, together with the purpuric rash seen on his arms.

Examination.—This is not typical in its findings, inasmuch as he has been ill one month. Temperature 99.8, pulse 100, soft, regular. He is of slight build, sallow complexion, an anemic in appearance.

Eyes.—Sclera clear, mucous membrane slightly pale, pupils normal.

Nose.—Mucous membrane normal; no history of epistaxis.

Mouth.—Tongue clear; mucous membrane slightly pale.

Pharynx.—Congested; smears show streptococci and diplococci. Thyroid negative.

Chest.—Lungs normal; heart normal; hemic murmurs absent.

Abdomen.—Habitus broad; liver and spleen normal. No pain or tenderness in stomach or intestines. Has not had any pain, diarrhea or vomiting at any time.

Skin.—Face, abdomen and chest clear. The extremities are thickly covered with a purpuric ecchymosis. The rash varies from the size of a pin-head to that of a dime and has a tendency to coalesce. The rash appears in crops, apparently; when first appearing being bright red, later turning a chocolate color and gradually fading away. Itching is present, but not pronounced. There is no edema of the skin at present, nor does the history elicit any evidence of this symptom, except the swelling, now moderate about the knees and elbows. These joints are still painful.

Examination of the blood shows only a slight secondary anemia. Hemoglobin (Talquist) 80 per cent.; reds, 3,500,000; normoblasts, few; whites, small lymphocytes 15 per cent.; large lymphocytes 3 per cent.; polymorphonuclears 76 per cent.; eosinophiles 2 per cent.; myelocytes none. Coagulation time increased fifteen minutes. (Drop method.)

Stool.—No occult nor macroscopic blood.

Urine.—Albumin present; many red blood corpuscles; a few leukocytes and comparatively

many blood casts are present. The only apparent blood-leak (exudation), therefore, is in the skin and kidneys.

Diagnosis.—From previous history, especially sore throat, arthritis and purpura, and present symptoms, the diagnosis of purpura rheumatica or Schönlein's disease is apparent. He presents, in fact, a classical illustration of this disease. To differentiate from other purpuras, namely Henoch's (generally children), we have the age of the patient to guide us, also lack of gastro-intestinal symptoms such as diarrhea, pain, vomiting, no intestinal hemorrhages nor enlargement of the spleen. Toxic purpura from drugs, also that form of purpura associated with jaundice, may be ruled out by the length of the illness and absence of jaundice or existence of liver disease. Purpura hemorrhagica may be excluded inasmuch as this disease is typical to young girls and characterized by epistaxis and hemoptosis. There are no arthritic symptoms peculiar to this disease. Leukemia with hemorrhagic symptoms is accompanied by the splenic or glandular enlargement, plus the typical-picture, all of which are here lacking.

Treatment.—This is limited. In this case tonics and calcium lactate are being used, the latter being especially useful in increasing the fibrinogen content of the blood. Gelatin may also be given. Salicylates, on account of irritant kidney effects, must be given cautiously. Silver nitrate, 20 per cent., has been applied to the pharynx and tonsils.

Remarks.—The question has been raised whether we have a different form of arthritis in this case, as compared to the ordinary rheumatic form of arthritis. Some observers have noted a special streptococcus, differing from that usually found in rheumatic arthritis. Or are these purpuric forms of the same origin, differing only from the latter in the intensity of the infection, plus a low resisting power on the part of the patient? In this case, the portal of entry seems to be the pharynx. The tonsils are small, although the patient may have had a tonsillitis in the beginning. At all events, removal of the tonsil together with any infected crypts, would possibly assist in the elimination of future attacks.

Dr. W. A. Repp also outlined his method in preparing the field for operation and Dr. Plinn F. Morse demonstrated the technic of the Wassermann reaction and also the various staining methods of the *Spirocheta pallida.*

Acute Intestinal Obstruction

1. Digestive disturbances, with colic, following abdominal operations, should be treated with opiates and not by purgatives.

2. A suspected mechanical obstruction should never be treated or tested by purgatives by the mouth.

3. Under such circumstances the painful peristalsis should be quieted with opiates. Attempts to move the bowel should be made only with enemata.

4. Patients with suspected strangulation of the bowel, or with mechanical obstruction of any type that does not yield promptly to opiates, gastric lavage, purgative enemata and hypodermoclysis should be treated by section.

5. In all patients, except desperate cases that are operated on, a search should be made for the obstruction, provided no adhesions are present. This search should, if possible, start with the cecum, and should proceed up or down the gut, as determined by the flaccid or distended state of the cecum.

6. If the obstruction is not located after a brief search, enterostomy should be done at the lowest point in the distended gut that is practicable. This should be made by fastening in a rubber tube with sutures, after the manner of a Kader or Senn gastrostomy.

7. There is only one technical point that I wish to present. It concerns a plan I have used only once, myself, but it appeals to me as a good one. When resection is done for damaged gut and anastomosis is considered justifiable, use the lateral suture method, and establish gut drainage by fixing the proximal end of the gut in the operating wound or in a stab wound, after fixing a tube in it by two or three successive purse strings of catgut.

By this means the proximal bowel is given an outlet for its accumulations, and the suture is absolutely relieved from stress and strain due to distention of the gut. Spontaneous closure of the fistula is practically assured, since a portion of it is lined with peritoneum.—Barr, in *New York Medical Journal.*

Lumbar Puncture

1. Lumbar puncture is of great value from a diagnostic and therapeutic standpoint in other than true meningitis cases.

2. It has not yet received the endorsement it should have and it is not used as often as it should be by the general practitioner.

3. It is the only prompt and sure way to secure a positive diagnosis in cases showing suspicious meningeal symptoms, whether alone or accompanying some other disease.

4. Therapeutically, by relieving the brain pressure it is much more prompt and effective than drugs.

5. Many cases showing suspicious meningeal symptoms clear up almost at once after a lumbar puncture.

6. In the treatment of convulsions from any cause it is a remedy that is of great value.

7. Its technic is simple and it should be promptly and easily done by the general practitioner.—Wynkoop, *Archives of Pediatrics.*

The JOURNAL of the Michigan State Medical Society
ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

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The Society does not hold itself responsible for opinions expressed in original papers, discussions, communications or advertisements.

Subscription Price—$2.00 per year, in advance.

JULY

Editorials

THE FLINT MEETING

Elsewhere in this issue the reader will find a complete list of the hotels of Flint, and the accommodations they will be able to furnish for the members who will attend the annual meeting at Flint. In addition, there is given the address of the chairman of the committee who will provide all who write him with accommodations in private boarding and rooming houses that are first class. We would suggest that there be no delay in making your hotel or room reservations in order that the committee may be enabled to arrange and provide suitable accommodations for everyone.

The August number of THE JOURNAL will contain the preliminary program of the meeting and will be known as the Flint Number. The September JOURNAL will be mailed on August 25, and will contain the entire program for the two-days' meeting.

The efforts that are being put forth by the chairmen and secretaries of the various sections indicate that this meeting is going to be of exceptional value and a very profitable one to all who attend. The acceptance of the invitations extended to outside men to be present and read papers warrants us in making this prophecy. No member can really afford to miss this meeting.

The Flint profession is bending every effort and energy to make the visit to Flint one that is mingled with profit as well as pleasure, and that their guests may be provided with every comfort and facility. It is desired that their efforts in our behalf may be rewarded with a large attendance.

Many of the members will undoubtedly desire to drive to Flint in their automobiles. To facilitate such a trip the August number will contain a detailed description of the principal automobile routes to Flint. Garage accommodations will be provided for by the committee on arrangements, who will select an official garage. Meet your friends in Flint on September 4 and 5.

WASSERMANN TEST

This valuable test, while not a true specific biological reaction, has weathered the storm of criticism and numberless modifications until today it is considered an indispensable aid in serological diagnosis and guide in therapeutics.

The strongest ground for criticism was based on the fact that no true antigen for the test for the presence of syphilitic antibodies could be obtained.

From the large number of lipoid substances that will act favorably as an antigen, this criticism in a measure is correct. On the other hand, the clinical specificity of the test is daily proven and fills a most valuable link in the chain of diagnosis.

The complex technic of the original test led at once to numberless attempts to modify and simplify it. With all these modifications, the original stands preeminent, the principal value of the modifications being that of checking different steps of the original test.

A well-controlled, strongly positive Wassermann shows the presence of luetic infection with but few remote exceptions, while a weakly positive reaction is uncertain and the blood should be retested in doubtful conditions. Whether such reactions are the indication of by-gone infection or still active infection is still a subject under discussion.

However, the prevailing opinion regarding a positive Wassermann at any stage of the disease is that it indicates active lues.

The popularity of the test is steadily increasing and the percentage of positive reactions is also increasing. This is the direct outcome of more careful and skilful laboratory technic.

The aim to obtain a pure antigen from pure culture of the organism is now attracting attention, hoping to thereby perfect the test biologically. Experiments thus far have not proven this, and some investigators now believe there is no true antigen. The antigen now being successfully used in this test is combined antigen, composed of spirochaetae and pure lipoid substance. Therefore, the antibody-producing antigen of syphilis is a toxolipoid.

Through such a test we have been greatly assisted in not only obscure infections, but we are now compelled to examine the relations and associates of the infected person for further spread of the disease.

The assistance of the test as a therapeutic guide is of extreme value, providing an accurate estimation of two or more tests is obtained before any treatment is administered.

However, after treatment the test is of far less value unless a previous accurate estimation of the patient's resistance had been made, as all recognized medical treatment will alter the blood content, masking the original condition.

This test so utilized is of extreme assistance, and is gaining followers daily.

H. R. VARNEY.

HOTELS OF FLINT

Accommodations for the Annual Meeting, September 4 and 5.

Hotel Dresden, Official Headquarters, accommodations for 300, American. Rate $2.50 up.

Hotel Bryant, accommodations for 100, American. Rate, $2.25 up.

Hotel Reed, accommodations for 64, American. Rate, $1.25 up.

Hotel Crystal, accommodations for 62, American. Rate, $1.25.

Hotel Dayton, accommodations for 46, American. Rate, $1.25.

Chairman Hotel Committee, Dr. W. G. Bird, Flint.

In addition to the above hotel accommodations, members who desire a room in a first class private rooming house or private home may secure such reservation by addressing Dr. H. A. Stewart, Flint, Mich.

Members desiring further information may secure such information by either addressing the State Secretary or the Flint Committee on Arrangements, the personnel of which is: Dr. H. E. Randall, Chairman; Dr. C. B. Burr; Dr. J. G. Manwaring; Dr. H. A. Stewart; Dr. W. S. Bird; Dr. W. S. Knapp, Chairman of the Reception Committee.

THE FOURTH OF JULY

The "Sane Fourth" propaganda has become so fairly well established that the present time calls for but little comment. The ends attained and the value of the propaganda should not be lost sight of, on the contrary we should automatically apply the knowledge acquired and thereby lessen still more, if not entirely prevent the casualties that still occur in the present-day method of celebrating our national birthday.

"Love of country is a natural and praiseworthy attribute." The normal individual likes to give expression to it on this occasion in a spectacular and noisy fashion. Custom has established the method of manifesting this love in the form of firearms and fireworks, and we are somewhat loath to give up the recollections and joys of our boyhood days, which we vividly recall while assisting our own children in celebrating our nation's day of birth. Admitting that we find it difficult to reconcile ourselves to a "Fourth" without the firecrackers, pistols, cannons and fireworks, and granting that by reason of these early recollections we desire to perpetuate its noisy and explosive features, we also admit that the fearful aftermath of casualties of former years demand that we restrain our spirit of exuberance and limit our demonstration to those "noise-producing contrivances," whose use is less liable to be attendant with serious accidents.

The almost inevitable concomitant of Independence Day celebration—tetanus—takes its toll from those who have participated in celebrating the day with the dangerous explosives of former years. Many of these explosives have been either forbidden or rendered more safe. New contrivances equally as dangerous, and some of the older ones, still remain on sale, and as long as they are sold, accidents, more or less serious, and deaths will be recorded by the press on "the day after."

The list of fatalities will, however, be lessened and the death roll shortened if we but observe a little precaution and care in our treatment of these injuries. Antitetanic serum promptly used on the occurrence of suspicious injuries will minimize the fatality from this source. The loss of sight, or of a finger or limb can be obviated by discountenancing the sale of destructive agents by educational and publicity measures.

We urge the free and early employment of antitetanic serum and suggest that you make it a point to see that your druggist has an ample supply on hand for prompt use in the injuries resulting from the celebration of the nation's birthday.

THE CLINICAL THERMOMETER

Criticisms have oftentimes been directed against the clinical pocket thermometer of a physician as a conveyor of contagion and as being unsanitary by reason of the lack of attention that it receives after being employed in one case and before being used in the next one. These criticisms, due to the absence of definite measures to cleanse and sterilize it after each time that it is employed have arisen from the intelligent layman as well as from the physician and, we admit, rightly and justly.

The mere dipping in a glass of water and the wiping off on a clean towel or napkin does not render it clean or sterile—any more than would a similar procedure sterilize a scalpel that had been used to open an abscess—neither does such a process satisfy the requirements of those possessing more esthetic tastes.

We admit the pertinence of the criticism, but hesitate in endeavoring to point out a solution whereby the objections, yes and the dangers, may be overcome. The holders that have been placed on the market have proven unsatisfactory, as is evidenced by their lack of universal adoption. The suggestion that each family possess its own clinical thermometer—the best solution of the problem we know of at the present time—cannot be followed in every instance.

Admitting then the need of more careful and detailed consideration of this feature of our clinical work, THE JOURNAL is asking its readers to discuss this question and to describe their practice and to address their discussion and suggestions to the editor for publication in future issues. May we not have your view and suggestion?

GUY LINCOLN KIEFER, M.D., D.P.H.—A RECOGNITION

In the service of medicine and surgery there are definite branches which alone may properly challenge the entire thought and attention of any one man for the entire period of his life, and thus it is that practitioners of marked ability see fit to direct their course to specialties, perfecting themselves in knowledge pertaining thereto and the practical work implied. From among those whose activities have been thus directed in Michigan—we are proud that Michigan has a goodly number of such men—our attention is directed at the present time to Dr. Guy L. Kiefer of Detroit, who has, during the past month, tendered his voluntary resignation as Health Officer after having served Michigan's metropolis in that capacity for a period of twelve years. The influence he has exerted, the reforms he has instituted, the problems he has solved in public health matters, have been reflected throughout the entire state, and it is but fitting that at this time we should chronicle the more important achievements of his administration.

Believing as we do that such a résumé is but a fitting acknowledgement of the good he has accomplished not only for Detroit, but also for the entire profession of the state, and that this résumé, in addition to recording his work, will serve to stimulate others to achieve similar accomplishments.

When, in 1901, Dr. Kiefer accepted the position of Health Officer of Detroit, that board had but twenty-four employees and an annual appropriation of $31,352. To-day the Health Department of Detroit employs 189 persons, exclusive of hospital employees, and its annual expenditures approximate $240,000. These figures alone give one an insight into the magnitude of the department and the work that is accomplished, as well as demonstrating the executive ability that is demanded from the individual who assumes the directorship of its efficiency. The steady increase of population and the rapid growth of certain localities of the city by reason of the automobile industries has called forth the necessity of reorganization of the different departments, and one by one the Department of Vital Statistics, Contagious Disease, Milk and Dairy Inspection, Child Welfare and Department of Publicity and Public Instruction have been reorganized and their work rendered more efficient and capable of fulfilling the demands made on them by modern sanitary health requirements.

The municipal hospital at the present time is capable of caring for eighty cases of scarlet fever and diphtheria, eighty-five cases of tuberculosis and twenty cases of small-pox. There are under course of construction buildings which, when complete, will enable the department to render hospital care to three hundred and thirty-five persons suffering from contagious diseases.

The Child Welfare Department, which has for its particular duties the prevention of infant

DR. G. KIEFER

mortality and the following-up of sick school children, is a new innovation, the value of which has been satisfactorily demonstrated.

The Board of Health, through its Health Officer's recommendation and labors, has secured the enactments of many amendments to our health laws of the state and the sanitary ordinances of Detroit.

We might continue and enumerate many other lines of endeavor, and justice cannot be done to the subject of this article unless one recorded in detail the reports and recommendations of the Detroit Board of Health for the past twelve years. As an indefatigable worker, Dr. Kiefer has accomplished phenomenal results, and his activities have gained him a reputation that is not confined to his native city. In the state he has been called in consultation by those cities or communities that were confronted with crises in public health matters of their vicinity. In addition he has, whenever possible, accepted invitations to address various organizations and gatherings on topics germain to public health and sanitary regulations.

Nationally, he has appeared before the health organizations in the rôle of speaker, essayist and official. As chairman of the Section on Preventive Medicine and Public Health of the American Medical Association he presided at the Minneapolis meeting of that section. Possessor of a wide reputation as an authority on matters of health and sanitation his resumption of private practice will witness the retirement of a thoroughly efficient and capable health official—one whose career and labor may be pointed to with merited pride.

Recording then as we do his retirement from public and official life we are also happy in the fact that Dr. Kiefer is to remain in the state and devote his future time toward preserving his father's practice, which has been in the family for sixty-four years. The Board of Health of Detroit, in accepting his resignation, tendered him the position of consulting diagnostician.

THE JOURNAL extends to Dr. Kiefer its congratulations on having completed such a meritorious public career and at the same time conveys its best wishes for a long and remunerative private practice.

AN APPEAL

Of the fifty-nine county medical societies and twenty-one affiliated counties requested last April to send report to your Public Health Committee of work done or planned for the year 1912-13, but thirteen responded. Of these, six acknowledged no work done or planned (see STATE JOURNAL, May). During the last fiscal year the STATE JOURNAL has published reports monthly of the regular meetings of twenty-six societies which are doing most excellent work instructing the physicians, but no allusion to what each society is doing for the direct education of the other citizens of the state. We know indirectly that in

each of our larger cities there is united effort with the churches, schools, women's clubs and farmers' institutes, to convince the community that public health is individual wealth.

We fear there is a lack of awakened interest in the rural communities from which are derived the supply of milk, meat and all necessaries of life. It should be the aim of each division of public health work to arouse every citizen to the knowledge and prevention of contagious and infectious diseases; not alone of small-pox, tuberculosis, but scarlet fever, measles and especially typhoid fever, etc. With full knowledge of the cause of typhoid fever brought to each inhabitant, the way will be paved for pure water, effective sewerage, pure, clean milk and healthy food.

The physician in every community owes this knowledge to the people by whom he is surrounded.

Our new laws passed by the legislature this winter are excellent, but they need to be interpreted to the public in a manner they will heed.

This appeal is to every county medical society in the state, each to give an account of its public health work for the year, those who are doing much to point the way to those societies who are now doing special work in the direct line for public health.

At the state medical meeting in september, we hope to have a symposium and report from every county that each physician has added to the happiness and wealth of his community by his practical teaching on public health. Get busy; prevent typhoid fever and summer diseases among children in every community in our state.

FRANCES A. RUTHERFORD, M.D.,
Chairman, Public Health Committee.

VICTOR CLARENCE VAUGHAN, SENIOR

PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

The House of Delegates of the American Medical Association conferred this honor on one of Michigan's most deserving members of the profession at its annual meeting held in Minneapolis, June 16-20.

THE JOURNAL extends to Dr. Vaughan its hearty congratulations and rejoices that this honor has been bestowed on one who has so deservedly merited it.

Dr. V. C. Vaughan, Sr., was born in Randolph County, Mo., on Oct. 27, 1851, and graduated from the Medical Department of the University of Michigan in 1878. He is a member of the Washtenaw County Medical Society, Michigan State Medical Society and the American Medical Association. He has been dean of the Medical and Surgical Department of the University of Michigan since 1890. In 1904 he served as president of the Michigan State Board of Health. He served in the Spanish-American War, taking part in the Santiago campaign. He was major and surgeon of the Thirty-Third Michigan Volunteers. In 1900 he was made surgeon-general of the Spanish-American War veterans. In 1908-1909 he was president of the American Physicians' Association. He is professor of hygiene and physiologic chemistry at the University of Michigan. In 1872 he received the degree of B.S. at Mt. Pleasant, in 1875 the degree of M.S. at the University of Michigan and in 1876 the degree of Ph.D. He is a member of the Association of Pathology and Bacteriology, the Society of Bacteriology, the American Physiological Society, the Association of American Physicians, the Michigan State Board of Health, the Society of Experimental Biology and Medicine, the New York Academy of Medicine, the Chemische Gesellschaft, and is an honorary member of the French and Hungarian societies of hygiene.

Physician, teacher, author, original investigator, indefatigable worker for those health measures that tend to the prevention of disease and the prolongation of the life of all humanity, beloved and honored by every member of our state society Dr. Vaughan's election marks another epoch in the history of the profession of the state and indelibly writes the name of another of Michigan's men on the nation's medical roll of fame.

THE NOMINATING SPEECH BY DR. E. T. ABRAMS OF DOLLAR BAY

Mr. President and Members of the House of Delegates:

We are standing to-day on the highest mountain peak ever attained by the American Medical Association. During the sixty-four years that have past and gone into history we can plainly discern certain peaks that lie down and beyond in that great mountain range of time. These stand out and mark certain epochs in the history of this Association. To-day, just as truly as in the past, on the present mountain peak we are writing an epoch in the history of the American Medical Association, and this afternoon in the closing hours of this house, the founders of this great organization, the greatest on the face of God's earth, are looking over the battlements of

heaven to approve the action of the American Medical Association and its work.

I have in mind a man who answers and measures up to the full traditions of the former presidents of the American Medical Association. I am not conversant with his ancestral history, I am not conversant with his church relationship, or his criminology (laughter), but I am sure, so far as he is personally concerned, he is a man of character, a man of ability, a man of energy, and if elected to the presidency of the American Medical Association by your votes today, will lead this Association to higher and nobler and grander work than it has ever done.

Gentlemen, I have the honor and very great pleasure, Mr. President, to nominate Victor C. Vaugham of Michigan (applause).

THE CANDIDATES AND THE BALLOTING

Five names were placed in nomination for the presidency, those of Dr. Victor C. Vaughan of Ann Arbor, Mich., Dr. W. L. Rodman of Philadelphia, Dr. W. N. Wishard of Indianapolis, Dr. John B. Deaver of Philadelphia and Dr. H. Bert Ellis of Los Angeles.

Four ballots were taken before Dr. Vaughan was declared the choice of the delegates. On the first ballot Dr. Vaughan was third on the list, with Drs. Rodman and Wishard in the lead. On the first ballot the vote stood: Wishard, 32; Rodman, 25; Vaughan, 24; Ellis, 17, and Deaver, 15. Dr. Deaver, the lowest man, was eliminated.

On the second ballot the vote stood: Wishard, 39; Rodman, 33; Vaughan, 27, and Ellis, 17.

On third ballot Dean Vaughan showed his strength, tying Dr. Wishard for first place. The vote was: Vaughan, 40; Wishard, 40, and Rodman, 36.

INTEREST IS TENSE

When the final ballot was being taken the interest grew intense. There was hardly a physician in the hall who was not keeping tally of the votes. First Dr. Vaughan would be in the lead a few votes and then Dr. Wishard would come up. Dr. Vaughan made a steady advance, however, and when the vote was counted he was ten votes ahead of Dr. Wishard. The final vote was: Vaughan, 63; Wishard, 53.

OTHER OFFICERS

Other officers were elected as follows: First Vice-President, Dr. W. P. Conway, Atlantic City, N. J.; Third Vice-President, Dr. Lillian South; Fourth Vice-President, Dr. Sol G. Kahn, Salt Lake City, Utah; Secretary, Dr. Alexander R. Craig, Chicago (reelected); Treasurer, Dr. William Allen Pusey, Chicago (reelected).

TRUSTEES ELECTED

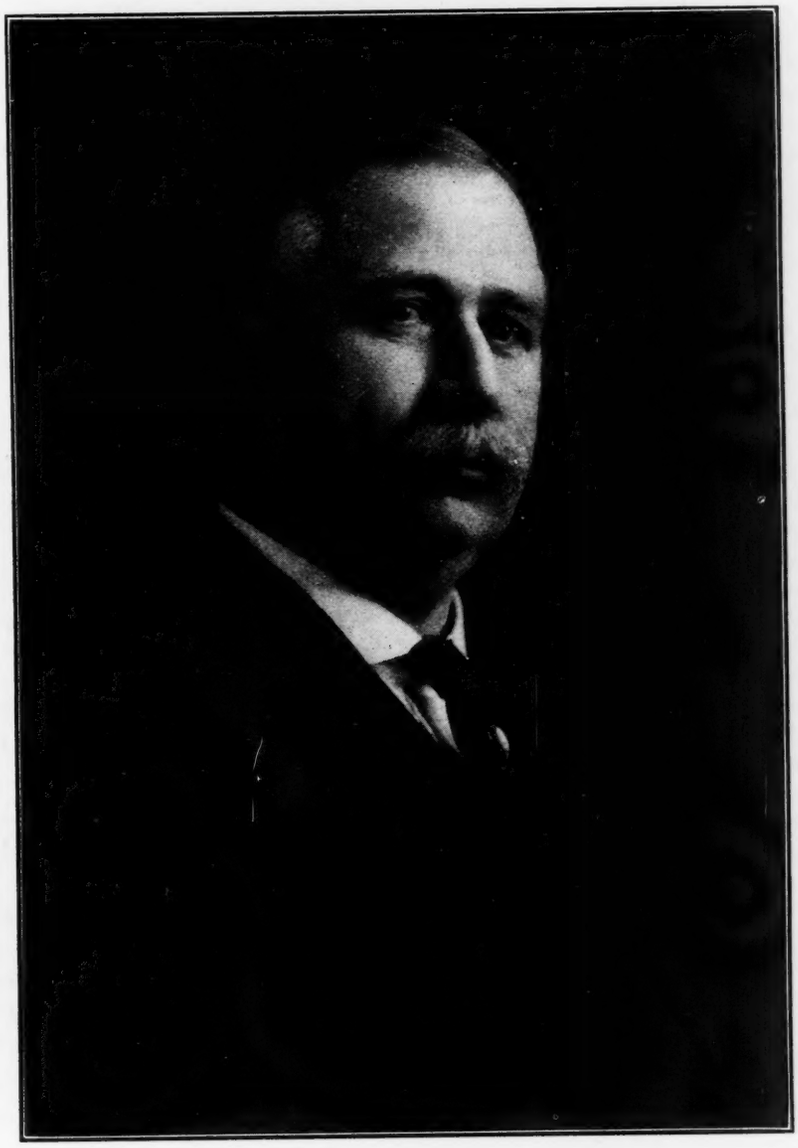
The following new trustees were elected: Dr. W. W. Grant, Denver, Colo.; Dr. Frank C. Lutz, St. Louis, Mo.; Dr. Oscar Dowling, Shreveport, La., and Dr. Thomas McDavitt, St. Paul, Minn.

NEXT PLACE OF MEETING

Atlantic City was selected as the place for holding the 1914 Annual Meeting.

MICHIGAN MEMBERS IN ATTENDANCE

Abrams, Edward T., Dollar Bay.
Adame, R. W., Kalamazoo.
Adams, R. U., Kalamazoo.
Agnew, J. Howard, Ann Arbor.
Bachelder, Frank S., Pontiac.
Baeslack, Frederick William, Detroit.
Barth, Louis, Grand Rapids.
Bell, John N., Detroit.
Bird, William G., Flint.
Blanchard, F. N., Detroit.
Boulter, J. H., Detroit.
Boys, Charles E., Kalamazoo.
Bradley, O. H.
Brown, George Van Amber, Detroit.
Brown, John N. Elliott, Detroit.
Brunson, E. E., Ganges.
Buckland, R. S., Baraga.
Burdick, Austin F., Lansing.
Camp, Carl D., Ann Arbor.
Canfield, R. Bishop, Ann Arbor.
Carstens, J. H., Detroit.
Case, James T., Battle Creek.
Clarke, Homer E., Flint.
Cleland, James, Jr., Detroit.
Colver, Benton N., Battle Creek.
Connor, Ray, Detroit.
Cooley, Thomas B., Detroit.
Crane, Augustus Warren, Kalamazoo.
Crosby, John H., Plainwell.
Darling, Cyrenus G., Ann Arbor.
De Foe, W. A., Saginaw.
Dodds, John C., Detroit.
Edmister, Frederick, Detroit.
Eggleston, E. L., Battle Creek.
Emerson, Francis P.
Fenelow, M. P., Escanaba.
Ford, Walter D., Detroit.
Freund, Hugo A., Detroit.
Haass, E. W., Detroit.
Haggen, C. M., Detroit, 371 Twenty-First street.
Herrick, A. W., Bay City.
Hewlett, A. W., Ann Arbor.
Hickey, Preston M., Detroit.
Hirschberg, Frieda, Grand Rapids.
Hirschman, Louis J., Detroit.
Hitchcock, Charles W., Detroit.
Holes, J. J., Battle Creek.
Hornbogen, A. W., Marquette.



VICTOR CLARENCE VAUGHAN, SR.
President-Elect, American Medical Association.

Hume, Arthur M., Owosso.
Hutchinson, R. J., Grand Rapids.
Jackson, John B., Kalamazoo.
Jennings, Charles G., Detroit.
Johnston, Collins H., Grand Rapids.
Kane, David M., Sturgis.
Kiefer, Guy L., Detroit.
Knapp, Harry B., Ionia.
Larned, Ezra Read, Detroit.
Larned, F. J., Greenland.
Lescohier, A. W., Detroit.
Loranger, Philip J., Detroit.
McAlpine, A. D., Detroit.
McGregor, Robert, Saginaw.
McKean, Geo. D., Detroit.
McKinnon, John D., Calumet.
McLean, Angus, Detroit.
MacMillan, J. A., Detroit.
Macqueen, D. K., Laurium.
Martin, W. F., Battle Creek.
Mercer, R. E., Detroit.
Moloney, F. J., Sault Ste. Marie.
Moore, Geo. E., Ironwood.
Morse, Plinn F., Detroit.
Mortensen, M. A., Battle Creek.
Nelson, A. W., Battle Creek.
Noordewier, A., Grand Rapids.
Oakman, C. H., Detroit.
Odeir, Rudolph J. E., Cadillac.
Parker, Walter Robert, Detroit.
Parmeter, Rolland, Detroit.
Pierpont, David C., Ironwood.
Poppen, Henry J., Holland.
Potter, G. E., Detroit.
Robinson, A. L., Allegan.
Robinson, Fred W., Sturgis.
Rutherford, Frances A., Grand Rapids.
Schillito, Frederick, Kalamazoo.
Shurly, Burt R., Detroit.
Schmidt, Harry B., Ann Arbor.
Simpson, Clarence E., Detroit.
Smith, Richard R., Grand Rapids.
Stockwell, Glenn W., Detroit.
Swinton, Andrew L., Ontonagon.
Taylor, Wesley, Detroit.
Thompson, Louise Rosenthal, Grand Rapids.
Townsend, Fred, Sault Ste. Marie.
Urquhart, John H., Ironwood.
Vaughan, J. Walter, Detroit.
Vaughan, Victor C., Ann Arbor.
Vaughan, Victor C., Jr., Detroit.
Vandeventer, V. H., Ishpeming.
Van Zwaluwenburg, Jas. G., Ann Arbor.
Varney, H. R., Detroit.
Volmar, Maud J., Battle Creek.
Warnshuis, F. C., Grand Rapids.

THE IMPORTANT TRANSACTIONS OF THE HOUSE OF DELEGATES

The passing of certain amendments to the constitution and by-laws whereby every member of a county society becomes a member of the American Medical Association and every such member who pays an annual dues of $5 becomes a fellow of the American Medical Association.

The condemning of the evil secret fee-splitting and providing for the dropping from the membership roll of the association every member found guilty of this practice.

The appointment of a committee to arrange for a joint meeting of the American Medical Association and the British Medical Association.

The empowering of the Board of Trustees to provide for the erection of a suitable monument to commemorate the sanitary work accomplished by the men in charge of the sanitary and health work in connection with the building of the Panama Canal. Such a monument to be erected on the sight designated by the U. S. authorities.

The election of Samuel Hopkins Adams, to associate membership in recognition of his work in connection with the propaganda against the patent medicine evils.

Routine work and committee reports.

Michigan's four delegates were in attendance at every session of the House of Delegates.

THE SECTION MEETINGS

The section meetings were characterized by the high scientific standard of all the papers and the discussions were not only interesting but instructive and men did not hesitate to express their disagreement and differences of opinions. The section meeting places, in spite of two days of extremely humid weather, were always crowded with attentive listeners.

The meetings were all held in the various buildings on the campus of the University of Minnesota. The arrangements were ideal and the accommodations were ample.

The profession of Minneapolis and St. Paul left nothing undone in their work of entertaining the visiting doctors. The total enrollment was 3,759, and with the ladies the visitors entertained

was estimated at 5,000. Complimentary lunches were served to all at noon on the campus.

On Wednesday evening the Minneapolis physicians gave a reception and dance. On Thursday evening the St. Paul physicians gave a vaudeville and luncheon in the Auditorium.

The ladies were entertained at Lake Minnetonka on Wednesday, Lake Interlachen on Thursday, and with automobile rides on Friday.

Every departing physician had nothing but the kindest words for the whole profession of the "Twin Cities." This sixty-fourth session was unquestionably a most successful meeting.

Editorial Comments

THE Flint members of the profession are eager to have you attend the Annual Meeting, September 4-5. Comply with their desires and plan to go.

YOU will get out of your county society just what you yourself put into it. The trouble often exists in the fact that we are always looking toward having the other fellow do the work, while we personally feel disposed to sit back and enjoy the benefits without turning a hand toward bringing about better things. You are going to get out of your society just what you put into it, and if you are getting nothing you may rest assured that you are putting in nothing.

The fear expressed in an editorial in the March JOURNAL that Friedmann was evidently suffering from an "itching palm" was warranted when one stops to review the course that he has pursued since arriving in New York. The assigning of the American rights for the use of the serum to a corporation in return for a sum of money and stock in the new company justifies the charge of commercialism. The advice that "the profession assume a position of critical neutrality" is still applicable and to the point.

THE necessity of patronizing our advertisers is so important that we feel justified in addressing to our readers a little sermonette on this topic from month to month. We feel very strongly on this subject and unhesitatingly declare that it is your duty to patronize our advertisers.

These advertisers make THE JOURNAL possible. Without their support we would not be able to send you a publication one-half the present size. To secure advertisers it is necessary that they should be the recipient of our business; advertisements must bring returns, or else they will be discontinued.

Patronage extended to our advertisers means that other firms will be willing to insert their copy in our columns, and our reputation for being a valuable medium will become established in the advertising world. More advertisements means a larger, better and more valuable JOURNAL for each member—twice the present size if possible.

We guarantee our advertisers to you and urge very strongly that you consign your orders to them whenever and as often as possible. Do this if you desire a larger, more fully illustrated and interesting JOURNAL.

THE PUBLIC HEALTH PAGE is considered to be one of the important departments of this publication, and is worthy of careful perusal by every reader. The scope of usefulness of the physician to-day is not confined to the drug shop, the laboratory, the sick room or the hospital. It should take in that greater province of usefulness—the education of the public at large. The enlightening of the public as to what is required for the physical welfare of the babe in the cradle, the boy or girl in the school, and both when entering on life's duties is the larger field of usefulness toward which we should direct our efforts in addition to the other demands that are made on us for the alleviation and cure of the sick and distressed.

The history of our profession is filled with numerous incidents detailing the influence it has exerted in shaping the intelligence of the public so that they might, by a knowledge of Nature's laws and phenomena, better their hygienic and physical surroundings. The time has not yet arrived when we may rest on our oars and consider that we have imparted to the world at large all the information that is necessary for them to possess in order that they may be enabled to avoid the many pitfalls of disease and disaster. We have still to be aggressive and in order that our readers may be kept abreast with the developments in the field of public health measures, we have very fortunately been able to secure the collaboration of Dr. E. G. Dixon, Secretary of the State Board of Health, who will edit this department of THE JOURNAL. We are certain that it will contain many valuable points and suggestions.

THE medical profession of Indiana is in the midst of a state-wide "anti-fee splitting" agitation, which was precipitated through a letter from a leading surgeon published in *The Journal of the Indiana State Medical Society,* in which the evil was condemned in a very emphatic manner, and an invitation was extended to the medical men to publicly register their positions in the matter. That good will result from the publicity that is being given to the subject in Indiana is already apparent.

The attention that has recently been directed toward this commission evil is slowly but surely working out the solution of the problem, and we are encouraged to believe that the evil is gradually being abolished. This publicity will soon cause those who are guilty of the practice of dividing fees to desist from asking or demanding a "divvy."

Michigan cannot claim that its professional skirts are unbesmirched by the stigmata of this evil. It has existed in our midst as extensively probably as elsewhere. Some seven or eight years ago the the surgeons of Grand Rapids met, and after discussing the subject they drew up a statement condemning the practice and pledged themselves to not consent to a secret division of fees. In previous issues of THE JOURNAL the evils of this system have been discussed in a series of editorials. The Detroit members of the profession have taken a firm position, and he who gives, solicits or receives a division of a fee is expelled from the local society, and should the offender be a member of the staff of Harper Hospital his staff position is automatically forfeited.

Another desirable and progressive step has been taken toward abrogating this practice in Michigan in the securing of the amendment to our medical practice law which provides that the state board shall have the power to revoke the right to practice of any physician convicted of being a party to the division of fees.

The remedy thus provided makes it possible to purge Michigan of this nefarious practice. We are of the opinion that this state has, by this action, assumed the position at the head of the entire body of medical men in thus determinedly endeavoring to bring about a state-wide discontinuance of secret fee-splitting. We plead that an aggressive attitude be assumed in securing the rigid enforcement of this law.

THE perfection that has been attained in the manufacture of automobiles warrants us in stating that the physician's problem as to the selection of the best means of conveyance while making his professional calls is no longer a matter of debate or worry. The owner of an automobile is no longer required to crawl under his machine, and while lying on his back perform a laparotomy on its internal "viscera." Tire difficulties have also been very satisfactorily overcome, and one may start on his professional rounds or emergency calls with the assurance that he will "get there and back" without undergoing a mental turmoil or "brain storm," providing he observes two precautions in the care of his machine. These two essentials are: Fill your gasoline tanks every morning, and second, keep all the running and moving parts of the car well lubricated—do this methodically, not once a week or every two or three weeks, but daily. This lubrication should not be limited to the engine, transmission and differential housing, but should include every grease cup and oil opening.

An experience of eight years with several models of cars has convinced us of the essentiality of these two necessities, and has enabled us to obtain more service and mileage out of a car than many another owner of a similar make machine.

In regard to tires, the lesson learned has been: First, to keep them fully inflated—not by guessing as to the pounds pressure, but by means of a tire gauge, and second, to at least once a week seal up the small cuts and bruises in the tread with plastic cement, thereby preventing destruction to the fabric, which is the principal cause of blow-outs. By so doing we have been able to obtain 10,000 to 12,000 miles' service out of a tire, and have gone months without having a flat tire.

The attention thus given to the lubrication of the automobile and the care of the tires has permitted us to enjoy numerous trips varying from 100 to 2,000 miles each, with the greatest peace of mind and absence of worry. One car that has received this attention has gone 35,000 miles, and to-day is in first class running condition, and does not compel us to take anyone's dust or cause us to ponder whether it is nearing the time when it will meet the fate of the "Deacon's One Horse Shay."

One suggestion more and this comment on automobiles will be brought to a close. Avoid an attack of "tinkeritis." If you are already afflicted with this expensive ailment we would recommend a course of active treatment directed

toward securing your recovery. Such treatment should consist of the following measures: Have the car tuned up by a reliable mechanic — we admit that in some localities they are hard to find —stay away from the garages and repair shops when the car has been properly adjusted; lock up your tool box and throw your key away—all the tools that you really need are a pair of pliers and tire irons. True, there may be days when your car does not "hit them off as smoothly as before," but this is occasioned by atmospheric and climatic conditions, and does not call for readjustment. In an hour or two your motor will be running along in sweet "tune."

Barring accidents or unusual breaks, your trips to the repair shop should consist of two trips a year—spring and fall, when valves should be ground, worn piston rings replaced and bearing taken up. The life, utility, reliability and endurance of an automobile depends more on what one should not do than on the things one feels unaccountably disposed to do. Once they are properly adjusted, keep your hands off your carburetor, magneto, timer and valves, and less trouble and added enjoyment will fall to your lot. The exercising of a little judgment and discretion will obviate many unnecessary difficulties.

State News Notes

Dr. Roxie Bates has moved from Oak Shade to Morenci.

Dr. F. W. Sassaman of Charlotte has been appointed city health officer by the local council.

Dr. G. W. Nihart of Petoskey has been appointed city health officer by Mayor Reycraft.

Dr. A. M. Campbell has been appointed chief of the staff of the U. B. A. Hospital, Grand Rapids.

Dr. George M. Lochner has been selected as the new health officer of Adrian to succeed Dr. F. E. Andrews.

Dr. Rollin H. Stevens of Detroit was elected president of the Detroit Society for Sex Hygiene on May 24.

Dr. J. L. Walsh, who has for several years been practicing at Watersmeet and Bonifas, has located at Iron River.

Dr. Charles S. Lane of Whitmore Lake has located in Hudson and has rented offices in the Boies State Bank Building.

Dr. J. Everett King of Detroit announces the removal of his office to 355 Woodward Avenue, corner High Street, Detroit.

The Battle Creek papers announce the election of Dr. W. H. Riley as a fellow of the Royal Society of Medicine in London.

Dr. F. C. Kidner of Detroit addressed the annual meeting of the Homeopathic State Society at its Grand Rapids meeting.

At the annual meeting of the Grand Rapids Academy of Medicine Dr. J. D. Brook was elected president and Dr. A. V. Wenger, secretary.

Dr. J. G. R. Manwaring of Flint tendered his resignation as a member of the Flint Board of Health and is succeeded by Dr. F. A. Roberts.

The Forward Movement Association of Saugatuck is planning to build a sanatorium for the charitable treatment of crippled children and feeble adults.

The hospital board of the Newberry State Hospital has appropriated $85,000 for the erection of new buildings and other improvements of that hospital.

The "Books Reviews" are worthy of your perusal. The opinions therein expressed by the reviewers may be relied on when purchasing new works for your library.

Dr. Edward T. Abrams of Dollar Bay delivered the address to the graduating class of the Detroit College of Medicine. Diplomas were granted to twenty-seven graduates.

Dr. I. N. J. Hotvedt and Dr. Jacob Oosting of Muskegon attended the Clinic Week of the Detroit College of Medicine. They drove from Muskegon to Detroit in their automobile.

The next annual meeting of the Michigan State Anti-Tuberculosis Society will be held in Kalamazoo in November. The annual meetings have formerly been held at Ann Arbor.

Dr. C. T. Southworth of Monroe spent the month of May attending the clinics of New York City. A week's stay at Atlantic City was made before returning home the first week in June.

Dr. A. H. Blackburn and Dr. F. G. Gilbert, 1913 graduates of the Vanderbilt University, have entered in on their duties as interns in the Butterworth Hospital, Grand Rapids.

After a lapse of two years during which he has devoted himself to the automobile industry, Dr. Wadsworth Warren of Detroit has resumed practice with offices in the Washington Arcade.

The Kent County Medical Society at its meeting on May 28 voted to instruct its delegates to extend an invitation to the state society to hold its 1914 annual meeting in Grand Rapids.

Dr. G. L. McBride was elected chief, Dr. R. H. Spencer, vice-chief, and Dr. Ralph Apted, secretary of the staff of Butterworth Hospital, Grand Rapids, at the annual meeting held June 2, 1913.

Drs. C. E. Boys, A. W. Crane, H. Ostrander and R. E. Balch of Kalamazoo attended the May 14 meeting of the Kent County Medical Society which was addressed by Dr. Paul Pilcher of Brooklyn, N. Y.

Through the generosity of Mr. and Mrs. Eben Pennock, two of the oldest residents of Barry County, the city of Hastings will be prvided with $20,000 for the erection of a hospital to be known as the "Pennock Hospital."

Dr. Nihart of Petoskey and Dr. J. L. Burhart of Big Rapids were callers at the secretary's office during the week of June 3. A cordial invitation is extended to every physician when in Grand Rapids to pay us a visit.

Senior Surgeon H. W. Austin, United States Public Health Service, has been assigned to duty at the U. S. Marine Hospital, Detroit, relieving Surgeon C. H. Gardner, who goes to Buffalo. Dr. Austin is a University of Michigan graduate.

The current reports that the amendments to the medical practice act, as published in the last issue of THE JOURNAL, have been declared unconstitutional are unfounded and incorrect. The amendments become effective ninety days after their passage.

Dr. Guy L. Kiefer, health officer of Detroit, spent several days in Alpena during the latter part of May and acted in an advisory capacity to the Alpena health officials in their campaign for a healthier city. He also addressed the Alpena County Medical Society on, "Preventive Medicine."

Plans for the development of the Detroit College of Medicine were discussed by the alumni at their last annual meeting. It was there announced that one-third of the $1,000,000 endowment fund is pledged. The alumni association has also raised funds for eleven scholarships of $250 a year.

Dr. W. J. Wilson, Jr., of Detroit sailed from Boston on June 12 for Naples. He expects to visit a number of the hospitals on the continent before attending the International Congress of Medicine in London. While in London he has arranged to do some work in diseases of the heart under the direction of Dr. James Mackenzie.

The following is a list of the new officers elected by the alumni of the Detroit College of Medicine at its last annual meeting: honorary president, Dr. C. G. Jennings; president, Dr. F. N. Blanchard, Detroit; vice-president, Dr. J. S. LaBelle, Windsor; secretary-treasurer, Dr. R. L. Clark, Detroit; trustees, Dr. George E. Potter and Dr. Walter J. Wilson, Jr.

The supreme court of Michigan has affirmed the conviction of Dr. C. J. and J. D. Kennedy, known as "Drs. K. and K.," who were fined $100 each in Detroit police court on charges of exhibiting an indecent museum in connection with their office. They appealed to the recorder's court and the conviction was upheld there. Then they carried their appeal to the supreme court.

Recent tabular statistics, published in *The Journal A. M. A.*, show that Michigan medical graduates are at least 10 per cent. better in their technical preparation than Harvard graduates, and 5 per cent. better than Johns Hopkins graduates. Statistics showing the result of state board examinations give the graduates of both of Michigan's medical schools a very creditable standing.

Governor Ferris has appointed the following as members of a commission authorized by the last legislature to purchase not less than 1,000 acres of land in Michigan and to establish thereon buildings and to organize the Michigan Epileptic Farm Colony. An appropriation of $200,000 is at the disposal of this commission for these purposes: Thos. Gordon, Jr., Howell; Henry S. Hulbert, probate judge, Detroit; Dr. R. L. Dixon, Lansing.

Sixteen of the twenty trustees proposed for the reorganization of the Detroit College of Medicine were elected at a meeting of the subscribers on May 15. These sixteen trustees are: Drs. J. H. Carstens, C. G. Jennings, Angus McLean, B. R. Shurly, Frank B. Walker and Messrs. J. B. Book, H. M. Campbell, Emory W. Clark, Edwin S. George, David Gray, Henry B. Joy, A. L. Lewis, S. T. Miller, Charles Moore, J. H. Walker and W. C. Williams.

Our attention has been called to an error that occurred in the article in the *Public Health Department*, page 349, June number. The article as printed reads: "We furnish . . . platinum foils . . . for sending blood. . . ." The word aluminum should be substituted for the word platinum. In calling our attention to this error Dr. Holm writes: "As a state department we are often criticised and accused of extravagance. Please correct the statement as it looks bad to the taxpayers."

Dr. D. S. Sinclair of Grand Rapids was elected president of the Homeopathic Medical Society of the State of Michigan at their forty-fourth annual meeting held in Grand Rapids on May 20. Dr. Sinclair is a member of the Kent County Medical Society and of the Michigan State Medical Society.

Action was taken at this meeting whereby the *Homeopathic Observer*, a publication issued by the faculty of the homeopathic department of the state university, was designated as the official publication of the society.

The commission authorized by the last legislature to make a survey and to investigate the extent, distribution and causes of feeble-mindedness in the state of Michigan has appointed Dr. W. H. Crane of Ann Arbor, as chief investigator. Dr. Crane is a well qualified man for this work, having had a great deal of experience along the lines of sociology, psychology and psychiatry. He will be assisted by at least three field workers, including Miss Adele McKinnie, who did work on this subject under the supervision of the State Board of Health, last year.

Deaths

Wilson, Clarence B., M.D. University of Michigan, 1890. Following a brief illness (complicated abdominal trouble), died at his home in Bradford, Vt., May 31, 1913, aged 47 years.

Holt, Charles H., M.D. University of Pennsylvania, 1882, member of Kent County Medical Society, Michigan State Medical Society. Died of apoplexy at his home, 103 Mt. Vernon Street, Grand Rapids, June 2, 1913, aged 59 years.

Sweet, Charles A., M.D. University of Illinois, 1887; member of the Charlevoix County Medical Society and Michigan State Medical Society. Died at his home, East Jordan, May 4, 1913, after an illness of several years; aged 53.

Stone, David F., M.D. Toronto University 1870, member of the Bay County Medical Society, Michigan State Medical Society, American Medical Association. Died May 16, 1913, at the home, 1715 Center Avenue, Bay City, following an illness of several years duration (paralysis agitans), aged 70 years.

Shurly, Ernest D., M.D. University of Buffalo, 1886; a member of the Wayne County Medical Society, Michigan State Medical Society and the American Medical Association; one of the founders and emeritus professor of laryngology and clinical medicine in the Detroit College of Medicine; President of the Michigan State Medical Society in 1898; member of the American Laryngological Association; formerly acting assistant surgeon in the Army with service in the Indian campaigns and the Yellowstone Expedition; a pioneer in the fight against tuberculosis; founder of the first tuberculosis camp in Michigan at Eloise; a specialist in the diseases of the nose, throat and chest, and author of standard works in his specialty; for many years chief of staff of the Harper Hospital and a member of the staff of St. Mary's, St. Luke's and Woman's hospitals; died in Harper Hospital, Detroit, after but a few hours illness, May 10, from heart disease, aged 67.

JESSE EARL WILSON, M.D.—1829-1913 *

BY M. W. GRAY

The decease of a physician who has successfully practiced his profession in one community for many years is an event worthy of more than formal record; but the death of one who had, for nearly sixty years, been foremost in his profession and a leading, public-spirited citizen, is a bereavement to many, a distinct loss to all within the sphere of his activities, and removes from society a force which cannot well be spared. That this is true was revealed and emphasized when the life of Dr. Jesse E. Wilson of Rochester closed and was attested by the universal expression of esteem and grief, and the many who mourned as though suffering a personal and irreparable calamity.

Born near Quebec, Canada, Jan. 31, 1829, Dr. Wilson was the son of Jeremiah Wilson, a Methodist minister. His parents were both American born, his mother's maiden name being Bailey. After adequate preparatory education he pursued his medical studies at the University of Michigan, Bellevue Hospital Medical College and Castleton Medical College, Castleton, Vt. He received the degree of doctor of medicine from the last named institution in 1855, located in Rochester, Mich., the same year, where he lived and practiced his profession until his death which occurred March 7, 1913. He married Susan Annette Richardson who died about thirty years ago.

When the village of Rochester was first organized in 1869, Dr. Wilson was elected its first president. He was continuously a member of the Board of Education forty-one years, forty years of the time being president of the board. He also filled many other offices of honor and trust.

He was formerly a prominent member of the Michigan State Medical Society and the Northeastern District Medical Society of Michigan. At the time of his death he was an honorary member of the Oakland County Medical Society.

The Rochester *Era*, in an obituary notice, said:

"To those with whom he came in contact in his professional work, his death brings keen sorrow. For long years many had looked to him for aid in their suffering, for advice and comfort in their deepest sorrow, when life seemed threatened and uncertain, and he never had failed them. To such the place of Dr.

* Read before the Oakland County Medical Society, June 5, 1913.

Wilson will be hard to fill and his memory will be kept green by the rememberance of his sacrifice and devotion to the saving of human life."

The biography of Jesse E. Wilson is nearly paralleled by that of his twin brother and coworker, Dr. Jeremiah C. Wilson, who came to Rochester in 1857. From this time the lives of Drs. Jesse and Jere, as they were familiarly and affectionately called, until the death of the latter in 1906, were as much alike as it is possible for the lives of two men to be.

Society Proceedings

ALPENA COUNTY

The regular meeting of the Alpena County Medical Society was held May 20, 1913, at the Alpena House, Alpena. Dr. C. M. Williams was the host of this occasion, Dr. Guy L. Kiefer of Detroit being the guest of honor. Those present were Drs. McKnight, Secrist, Dunlop, Bell, Cameron, Komoraski, Gauvereau, Leo Secrist, Small, Bertram, Bonneville, McDaniels, Williams.

Following the dinner the meeting adjourned to the Temple Theater, where Dr. Kiefer delivered a public lecture on "The Prevention of Disease." The lecture proved most instructive to the members of the society and very interesting to the general public. By reason of this lecture public health sentiment in Alpena has been greatly raised.

C. M. WILLIAMS, Secretary.

CALHOUN COUNTY

The Calhoun County Medical Society held its second quarterly meeting at the home of Dr. R. M. Gubbins in Ceresco, on Tuesday afternoon, June 3, with about twenty-five members present, besides several guests.

The usual business program was followed, during which two new members were elected, viz.: Robert V. Gallagher of Battle Creek and Maurice S. Gibbs of Eckford.

The scientific program was unusually interesting and instructive. Dr. Arthur R. Elliott of Chicago was present and delivered an able address on the subject of "High Blood-Pressure," treating the subject in an unusually pleasing and able manner. "The Value of Routine Examinations in Urological Cases," was the subject of a valuable paper by Dr. W. F. Martin of the Battle Creek Sanitarium. The latter paper will appear in a subsequent number of THE JOURNAL, and it is to be regretted that Dr. Elliott's address had not been so arranged as to permit of publication.

After the program, all present partook of a most sumptuous repast provided by Dr. and Mrs. Gubbins, "Under the Pines," at their residence.

A. F. KINGSLEY, Secretary.

GRAND TRAVERSE-LEELANAU COUNTY

Unusually interesting papers and discussions have increased the attendance at the regular meetings of the Grand Traverse-Leelanau County Medical Society the June meeting, held June 11, 1913, at Traverse City, being the largest this year.

Dr. G. W. Fralick reported an exceedingly interesting case of trichinosis in one of his patients. Another unusual case, one of kleptomania in a youth, was presented in a very interesting form by Dr. W. D. Mueller.

The society was so fortunate as to have as its guest Dr. Otto T. Freer, who spoke briefly on the advantage of a public medical library.

JAMES J. HALL, Secretary.

HOUGHTON COUNTY

The regular monthly meeting of the Houghton County Medical Society was held Monday evening, June 2, 1913, at the Scott Hotel, Hancock.

Dr. R. E. Wiley of Calumet gave a most interesting paper on "Anterior Poliomyelitis." The doctor gave a review of this disease from the days when it first became known down to the present day research that is being done so extensively. A good discussion concerning the possible modes by which the disease is transmitted, followed. Hardly a physician was present but had some of these unfortunate cases to report. Emphasis was laid on the physician's untiring efforts by means of the faradic and later the galvanic current in restoring the use of the muscles. Cases apparently hopeless, were finally restored to almost normal function, whereas others seemed to show no improvement, however judicious the treatment followed.

Dr. W. E. McNamara of Trimountain presented the next paper, "Transfusion of Blood." By means of charts the doctor showed the method used in this operation and the necessary instruments employed. Dr. McNamara reported five interesting clinical cases. One case was that of a hypernephroma in a woman in which the hemorrhage had been so profuse as to render operation hopeless. Transfusion was performed and later the operation for removal of the kidney was successfully performed. Another case was one of placenta previa in which all means to restore the woman were of no avail until transfusion was done, after which the patient made a good recovery. In a case of typhoid with hemorrhage, the patient was unconscious and the operation performed without local anesthesia. Before the operation was completed the patient spoke intelligently; patient lived eight days but finally died from further hemorrhage. Dr. McNamara does not advise resorting to transfusion as a routine measure, but thinks that the patient should be given this chance when other methods have failed.

This meeting was in the nature of a farewell to Dr. McNamara, who has been an active member since coming to this country. Dr. McNamara is to locate at Lansing, in company with Dr. Earl Ingram Carr, also of the Copper Range staff of physicians.

The meeting was adjourned to the banquet room and a good time enjoyed.

ALFRED LA BINE, Secretary.

KALAMAZOO ACADEMY

Program—Tuesday, May 13, 1913, 1:30 P. M., Academy Rooms, Public Library

BUSINESS MEETING—PAYMENT OF DUES

1. Report of Local Medicolegal Committee, Dr. Paul T. Butler, Kalamazoo, Mich.

2. "Law of Liability Pertaining to Physicians," Mr. Dallas Boudeman, Kalamazoo.

3. "Michigan Plan of Medical Defense," Dr. F. B. Tibbals, Detroit, Mich.

Practical Points in a Paper—"Some Observations in Anesthesia"—by Dr. J. B. Jackson, Kalamazoo

BEGINNING OF ANESTHESIA

Elimination of loud talking, laughing, discussion of operations, joking and story-telling about an anesthetic room during first stage of anesthesia.

Win the confidence of your patient. Deliberate and thorough examination of mouth, chest and general condition of patient helps to do this. Explanation of what will occur and what patient may expect and a weak vapor, more air than anesthetic, will reduce the struggling and resistance and fear to a minimum degree. Patient should blow out instead of taking deep breaths.

COURSE OF ANESTHESIA

Remove excess clothing, especially heavy shoes and hair-pins. Handle patient gently. Constant pressure on angles of jaw causes much discomfort subsequent to anesthesia.

Paralysis of muscles of lower arm sometimes occurs when arms are allowed to hang over table. Prolonged Trendelenberg position is bad for patient.

Insensibility to pain and relaxation of muscles are all that is necessary to obtain an anesthesia. Toxic conditions arise when anesthesia is profound; also in throat work, saliva and blood may be more easily breathed into lungs. Vapor through a tube is very helpful in throat work.

CHOICE OF ANESTHETIC.

Chloroform is most efficient to control pain in obstetric work, but when any surgical procedure is required in obstetric work ether is indicated. Some claim that ether is more irritating than chloroform; when ether is administered in vapor form, heated, it is not so irritating.

Medication: Gas and oxygen anesthesia are more satisfactory when morphin and hyoscin are administered before anesthesia. This method of anesthesia is pleasant, quickly produced and has apparently no toxic effects. It is expensive, and sometimes does not produce complete relaxation, except when medication is given beforehand.

Requirements for machine for administration of gas and oxygen are: First, an even, constant flow of the two gases without variation in the pressure; second, a single, easily regulated valve for accurately controlling the mixture; third, a simple, reheating apparatus; fourth, a mask that fits the face in an air-tight manner.

Facts Emphasized by Dr. John Ridlon in His Paper on "Etiology and Treatment of Hip-Joint Diseases"

Chronic hip-joint disease is primarily tuberculosis of joint. Tubercle bacilli may not be found. Patient may have limped but little for six months, but an x-ray plate shows extensive disease. Velvety appearance of head and socket and greatly enlarged. Details of head and socket destroyed. Mobility greatly reduced.

Patient limps because of the limited range of motion backward. Greater flexion, outward rotation, abduction, and apparent lengthening.

Limp is a restriction of action in all directions; when movement is free in all directions, not hip disease.

Atrophy of thigh and calf muscles next; in all cases of few weeks. Lengthening can only occur by destruction of joint.

Measurement to ascertain lengthening should be from anterior superior of ilium to internal malleolus. To measure from umbilicus to malleolus detects false shortening only. Fifty to 60 per cent. of limbs not equal in length—difference of one-half inch.

PAIN

Pain is felt in knee—distant pain, not local pain. Change of position at night gives rise to night cries. Tenderness about joint is a later manifestation, with joint abscess.

DIFFERENTIAL DIAGNOSIS

Confusion with Potts' disease. Lumbar disease—action of hip-joint free in all directions. Hip-joint disease mistaken for disease of sciatic nerve.

Saco-iliac Disease: Flexion deformity and restriction limited, but soon passes away.

Coxavara: Destruction of line between great trochanter and hip-joint. This occurs in fat people; boys with large hips—breast and sexual organs greatly reduced to those of a boy of 3.

CONGENITAL DISLOCATION

Greater than normal motion, restriction to rotation. Feel head of femur out of acetabulum.

INFANTILE PARALYSIS

Hip-joint movements more loose than normal.

Treatment: (a) Forceful correction. (b) Coaxing correction.

Mobilize hip traction with ten-pound weight over pulley on a board that is fixed, in direction of deformity. Plaster splint from ankle to nipple in position of deformity; reconstruct and correct deformity as much as possible every two to four weeks by reapplication of plaster splint until deformity is corrected. Plaster splint should be made with plenty of plaster, no cavities, no holes, no wrinkles, uniform thickness. When pain and tenderness disappear, patient may go on crutches with tall shoe on sound limb. Mechanical brace can only be applied by correct measurements and great deal of manual dexterity. Plaster splint is more simple. Bier's treatment and tuberculin condemned.

Clinical work at hospitals on April 22, last regular meeting: Perineorraphy, pelvic abscess, salpingitis with hernia, appendectomy, cysto-meningocele, decision of congenital cataract.

C. B. FULKERSON, Secretary.

KALAMAZOO ACADEMY OF MEDICINE

The regular meeting of the Kalamazoo Academy of Medicine was held June 10, 1913, at the academy rooms in the public library. Following several interesting case reports, Dr. A. E. West of Kalamazoo read a paper on "Routine Examination of the Urine." The discussion of this paper was opened by Drs. Hudnutt, Crane, Perkins and Shepard. Dr. L. H. Stewart of Kalamazoo presented a paper on "The Surgical Complications of Gall-Stones." Drs. Balch and Robinson opened the discussion which followed.

C. B. FULKERSON, Secretary.

KENT COUNTY

The Kent County Medical Society held its regular meeting at the Board of Commerce Chambers, Grand Rapids, on Wednesday, May 28, 1913.

Dr. A. M. Campbell demonstrated on a living dog, Soresi's method and technic for performing end-to-end anastomosis. This method is one that has been given publicity within the last few months, and is to be recommended for its simplicity and the short time necessary for its performance.

Dr. Ralph Apted gave a short talk on the "Present Status of the Alleged Tuberculosis Cure of Friedmann." This talk was followed by a general discussion, in which a number of the members participated.

The following case reports were given: "Four Cases in which Decompression Has Been Performed," by Dr. F. C. Warnshuis; Some Cases of Angina Pectoris," by Dr. J. B. Whinery; "Demonstration of Recovery from a Broken Back," by Dr. F. C. Kinsey; "A Case of Angina Pectoris," by Dr. Eugene Boise.

E. W. DALES, Secretary.

MECOSTA COUNTY

The Mecosta County Medical Society met on the evening of April 15 in the Club Rooms, with sixteen members and guests present. Papers were read as follows: "The Open Treatment of Fractures," by Dr. F. C. Warnshuis, Grand Rapids; "Medical Wit and Humor," by Dr. F. J. Groner, Grand Rapids. Both papers were well received and followed by interesting discussion. Dr. J. L. Burkhart demonstrated the working of a new vibratory machine. The meeting was followed by a supper and a short impromptu program at Theo Sellas & Co.'s Café.

C. F. KARSHNER, Secretary.

SAGINAW COUNTY

The regular meeting of the Saginaw County Medical Society was held in the mayor's office in the city hall, May 27, 1913. The program consisted of the following symposium: "Remarks on the Subject of the Evening," Dr. Robert McGregor; "Legal Aspects of the Sterilization Law," Senator G. L. Weadock; "Social and Psychological Aspects of the Sterilization Law," Dr. C. W. Mack, Pontiac State Hospital; "Surgical Aspects of a Sterilization Law," Dr. E. B. Smith, Detroit. Dr. Flynn, Bay City, was present and took part in the discussion. There was an unusually large attendance. The papers proved most interesting, the subject of a sterilization law being splendidly presented from the several viewpoints.

A. R. MCKINNEY, Secretary.

WAYNE COUNTY

The Wayne County Medical Society was called together for a special meeting by the vice-president, Dr. L. J. Hirschman, Monday night, May 12, 1913, at the Medical Building. Dr. Carstens spoke a few words in memory of Dr. E. L. Shurly, who has recently passed away. Dr. J. E. Clark spoke of his memories of Dr. Shurly, whom he had known for thirty-five years and held in the highest esteem. Dr. Robins moved that a committee of three be appointed to draw up resolutions on the death of Dr. E. L. Shurly. Seconded. Carried. Drs. Carstens, Robbins and Longyear were appointed. Meeting then adjourned.

The general meeting was followed by the regular meeting of the medical section. Dr. Hugo Freund, chairman; Dr. J. H. Dempster, secretary. The program, a symposium on Vaccine Therapy, etc., was upheld by Dr. G. H. Sherman, who read a paper on bacterial vaccine for the general practitioner. He advocated the early use of vaccine. Owing to the frequency of the various infections the speaker thought the employment of vaccine therapy should be more general than at present. "That bacterial vaccines are useful remedies which may be extensively applied is now generally admitted, and if the general practitioner aims to render the best service to his patient he should avail himself of their use." The physician should acquaint himself with the fundamental principles of immunization and familiarize himself with the use of vaccines. The importance of their early use was strongly emphasized. The great importance of vaccines as immunizing agents was mentioned.

DISCUSSION

Dr. George McKean stated that he was a user of vaccines and there was no question as to their use. There certainly was no question as to the prophylactic use of typhoid vaccine. He thought the number of typhoids would be less if prophylactic doses were administered more frequently. The speaker thought the early use of vaccine in puerperal sepsis a good thing. When you cannot produce another immunity with your vaccine, then is the time to secure a passive immunity with your serum.

Dr. A. P. Biddle stated that his experience consisted in the use of vaccines in special cases. He thought the mistake made was in not properly selecting the cases. Great harm had been done by indiscriminate use of vaccine. He thought vaccines as a routine treatment should be discouraged.

Dr. Robbins claimed that vaccines were of doubtful value in gonorrheal infections. There was no benefit in the acute cases. In some of the complications of gonorrhea they were reputed to be of great value. He would not object to the treatment by vaccines, provided the deep urethra were treated by other means.

Dr. Stafford claimed that the tried-out forms of treatment should be used in conjunction with the vaccines. Vaccines to be of use must be used early.

Dr. W. J. Wilson, Jr., cited a case of "gonorrheal bubo" which showed a marked reaction on a minimum dose which eventually cleared up.

Dr. Sherman closed the discussion.

The Wayne County Medical Society held its regular meeting May 19, 1913, with the president, Dr. Haass, in the chair; Dr. R. L. Clark, secretary.

The paper of the evening was read by Miss Charlotte A. Aikens on "Economy and Efficiency in Nursing in Families of Moderate Means." The families considered are those whose incomes run from $60 to $120 a month. The poor families are cared for by district nurses and the rich can pay the fees of trained nurses. This leaves uncared for a large class of the people who do not ask charity and do not want it. This drives many from the middle classes into the hospital, which, with proper nursing, could be cared

for in their homes. This multiplies nurses and adds to the competition in the nursing field.

The care of the sick as a whole has not been approached with a statesman's vision. The more cases which can be handled in dispensary and home will help to relieve the hospital. The whole problem must be met and studied in a business-like way. The nurse must be fitted to the requirements of the home. The hospital should only have the care of such cases as cannot be cared for in the home. There must be household nurses who will not be above doing some of the household work as well as care for the invalid in the home. These need not spend three years in learning to do things which they can never do in middle class households.

In several communities a system has already been developed in the caring of sickness in the home and the home in case of sickness. The organization determines what the case needs, whether a trained nurse or less trained assistance. They may need a trained nurse for a short time and then something less. This has been worked out at Brattleboro, Vt. Nurses should be of at least three grades: First, registered nurses with three years' training; second, certified nurses with one year's training, and household nurses who will help with household duties as well as the care of the sick. The small and special hospital, while not equipped to give full training, can give the essentials for household nurses.

The discussion was opened by Dr. J. N. E. Brown. A study of the needs of Toronto doctors showed a large proportion of their patients were in moderate circumstances and unable to employ trained nurses for any length of time. They suggested that nurses in training might be sent out into homes for a less fee than the graduates charge. This gives a chance for nurses to get a training in the home as well as in the hospital. Mr. Bradley of Boston is willing to help establish a nursing bureau in Detroit to furnish nursing to the middle classes of the city.

Dr. W. L. Babcock spoke on the practicability of training household nurses. The field for these workers is distinct from trained nurses. How, then, can these be trained? Nurses who train in special hospitals, insane hospitals, etc., might be utilized for those who need nurses at from $10 to $16 a week. The organization which has charge of such workers must have resources to recompense them adequately. The poor commission, rich people, factories and the like may help to make up the deficiency.

The workers are not all of a kind and command various wages.

A maternity nurse should not require more than a year's training. A good medical nurse ought to be well trained in two years, while a good surgical nurse should have at least three years. The hospital ought not to take charge of the training of the nurse in the home, although they should be willing to cooperate in this training.

Dr. Carstens spoke in favor of having obstetrical nurses, but has found that these soon attempted other things. Household nurses should be supplied who can be had for $8 to $10 a week.

Dr. Bell spoke of the need of the middle classes for nursing for a long period. They can stand this for a short time. Dr. W. J. Wilson spoke of the inability of the patient to pay both doctor and nurse, and hence no nurse is employed. The Wayne County Medical Society would be willing to co-operate with Mr. Bradley's scheme. Dr. Hirschman advocated the getting away from charity. Some sort of an insurance might be worked out to guarantee nursing during sickness to those who need it.

The following officers were elected for the ensuing year: President, L. J. Hirschman; vice-president, D. M. Campbell; secretary, R. L. Clark; treasurer, F. B. Tibbals.

R. L. CLARK, Secretary.

County Secretaries' Department

PLEASE do not forget to put this office on your mailing list and thus send us a copy of the notices of your meetings.

HAVE you notified the member in arrears with his dues as to what he is foregoing by allowing them to remain unpaid?

THE JOURNAL is desirous of publishing the report of every county society meeting. May we not have your report for the August number? We also want you to send us for publication the best papers that are read at your meetings. We can always use original articles.

THIS department is still awaiting for your individual opinions regarding organization work and your discussion of the problems that confront the county society. This is an open forum and you are invited to utilize this space either for imparting or securing information.

THE August JOURNAL will contain the preliminary program of the County Secretaries Association meeting at Flint, on September 3. If you have any suggestions to make regarding this meeting please communicate with the secretary of that association, Dr. C. T. Southworth, Monroe, Mich.

JUST as soon as the work preparatory for the annual meeting is cleared up we intend to visit every one of our county societies, and by so doing will become better acquainted with the various officials and members, and with the benefit of this acquaintance we anticipate that we will be better enabled to be of assistance to them in our organization work.

THE members of the Calumet County, Wisconsin, Medical Society are certainly "Night Hawks." One of their recent meetings was held at 10:30 p. m. and at 2 a. m. they adjourned to the dining-room of the hotel in which their meeting was held and "partook of coffee and luncheon," and in the words of their secretary: "The doctors left for their homes, having spent a pleasant and profitable evening." ? ? ?

WE will greatly appreciate your reporting the names of any of your members who are not receiving THE JOURNAL each month. Every member in good standing is entitled to THE JOURNAL and we desire that he receive it regularly. Permit us to also remind you to promptly report all removals and deaths. This cooperation will enable us to keep the records of the office properly corrected to date.

IF you have any men in your county who are non-members and are bound to be knockers, induce them to knock on your society door for admittance, and after admitting them proceed to show them that that knock—which should be the last one—was the best knock they ever made, and that their "little hammers" are to be retained only as a souvenir by which they may remember the folly of their erstwhile attitude during their preconverted days. Turn the *"Knocker"* into a *"Booster."*

"THE medical society is the continuation school of the physician. The changing conditions, trials and problems of medical education, the increasing requirements laid down by the colleges and medical boards are matters of vital importance and interest to the medical student of to-day, but the rapid changes and advances in the science and art of medicine itself, make the question of the continuous education of the physician one of most vital importance to him, and just here appears the highest function of the medical society: to provide, if possible, the means by which its members may preserve contact with the ever-advancing column and keep informed as to contemporary changes in our science and art, by presenting a modern program at the meeting and maintaining as good a library as the funds will allow." Thus spoke Dr. G. E. Seaman in his presidential address to the Milwaukee County Medical Society.

The value of the county medical society to the individual physician has often been referred to by various organization workers, but after all that has been said we must concede that the above accurately describes the foremost of all the benefits that may be derived from membership. We desire that every county secretary in Michigan bring this benefit to the attention of every eligible physician in his county who is not a member of the county society. Make him see that he cannot pursue his cloistered existence alone and not fall into a rut and thus be relegated as a private weakling to the farthermost rear rank of the organized physician—a straggler!

Individual missionary work on the part of the secretary is essential. There are members of the profession who are good men and who still remain unaffiliated. It devolves on you to personally interview them and in an honest open way point out to them the advantages that will accrue from affiliation with your society. Do this and you will be surprised to find that these non-members will be anxious to join when once you place the matter squarely before them. There are 1,000 doctors in Michigan who should become members of your and the state society. Will you not make it your special duty to at once commence a campaign that will not be permitted to terminate until they are elected members?

Even though the summer season is at hand it does not necessarily imply that the meetings of your society should cease until the fall. Automobiles and good roads have simplified transportation problems and distance is no longer so great an obstacle as it has been in the past. During the winter months it was a difficult matter for your rural members to reach your meeting place. Now that the roads are passable do not deny these men the benefit of your society meetings. Provide attractive and instructive programs. Enlarge on your social features and hold a meeting at least once a month and thereby enable these members who live at a distance to make up for what they lost during the winter when they were unable to attend by reason of bad roads and inclement weather. Induce them to take part in your programs and by so doing your summer meetings will more closely cement your professional relationships.

Public Health

THE MONTIETH BILL

The last Michigan legislature has been said by many, who are qualified to judge, to have surpassed any previous legislature in the enactment of laws which have for their purpose the safe-

guarding of the nearly three millions of Michigan citizens. These laws include many provisions for increasing the efficiency of our educational institutions; our banking laws have been materially strengthened; the insurance policies have been rendered more secure; the rights and welfare of labor and capital have received creditable consideration; good provisions have been made for the better care of the state's dependents, the deaf, the blind, the insane, the feeble-minded, the epileptic, the sick and crippled as well as the technically delinquent. Very soon, if not already, the public will become aware of the consideration given these subjects by the legislature recently adjourned, and certainly the thoughtful individual will declare that on the whole the laws passed by this legislature are decidedly creditable to the communities whose representatives took the active interest which was continually evidenced in the determination to establish laws whose aims and intents are better care and development of all personal, property and municipal rights and principles.

Several laws of vast importance from the public health standpoint were enacted. Each of these is worth the page of space allotted to this article. Among the most important ones might be mentioned the "Medical Practice Act," which gives the practice of medicine in Michigan, for the first time, a real technical legal standing; the "Nuisance Law," which makes it possible for a local board of health to abate or cause the abatement of a nuisance without having to unwind and again wind up an endless red tape, the "commission for investigating the causes, extent and distribution of feeble-mindedness, insanity and epilepsy," which shall report to the next regular session of the legislature the results of the investigation together with recommendations, the law providing for the "sterilization of feeble-minded," the establishment of an "epileptic farm colony," the provision of measures to "prevent blindness in the new-born," important measures to provide for the "purity of food-stuffs," provision for more adequate extension of the services of state and local boards of health, and the so-called Montieth bill, giving the State Board of Health supervision over every waterworks system and every sewage disposal system in this state.

Of this last-named law, it is in order at this time to make a few statements more, perhaps, of explanation of the law than anything else.

Local, or self-government, is an established principle of American political economy. We insist, as individuals, as families, as municipalities and as a nation, in running our own business, so to speak. This right has never been successfully contradicted. On the other hand, there is a principle of government, just as reasonably established, that as individuals, as families, as municipalities and even as a nation we may not so manage our affairs as to menace the life, limb and happiness or health of other groups of people if within our power to prevent. It is also established that the parent may not so manage the household as to prevent proper development of the physical, mental or moral principles of the child, the municipal governing body may not place the citizenship to disadvantage, nor may the federal government unduly embarrass the possibilities of the individual government units.

These may be said to be the fundamental policies underlying and confirming the provisions of the Montieth bill.

This bill provides that the State Board of Health shall employ for full time service a competent sanitary engineer, and through him shall serve the municipalities and people of this state by assuming, where necessary, control of waterworks systems and sewage disposal systems and causing the same to be so installed and so managed as not to constitute a menace to the health of the community and neighboring communities. This law provides that each municipality, private corporation, partnership and individual engaged in furnishing water to the public for household or drinking purposes, shall prepare and file with the State Board of Health complete plans and descriptions of all parts of said waterworks systems. The same provision is made in respect to sewage disposal systems. On receipt of these plans they shall be carefully studied by the State Board of Health and the sanitary engineer with reference to the effects which these systems may have on public health. Provision is made for supplementing these inspections by inspections of the systems themselves by the State Board of Health, the sanitary engineer or the state bacteriologist. Following these provisions the law reads as follows: "And if such board on such inspection finds that the public water-supply of any city or village is impure and dangerous to individuals or to the public generally, the said board on its order may require the corporation, partnership or individual owning and operating the same to make such alterations in such waterworks systems as may be required or advisable in the opinion of said board, in order that the water-supply may be healthful and free of pollution." The law further gives the State Board of Health

similar authority in relation to sewage disposal systems.

This, we believe is one of the most valuable laws passed by the legislature. In relation to public health there is no question of more importance to the people of this state than the questions of water-supply and of sewage disposal. A general consideration of our typhoid epidemics and occurrence of other diseases easily proves this fact. In this relation it is suggested that a study be made of *Hygienic Laboratory Bulletin No. 83,* which can be secured free from the United States Public Health Service, Washington, D. C. This bulletin is almost entirely devoted to a study of Michigan water-supplies and sewage disposals in relation to disease.

The inter-relation of our municipalities is very important on account of our large lake borders and many rivers. The purity of any municipal water-supply is of more than local concern; it is of vital interest to neighboring communities and to the state at large. The disposal of a municipality's sewage is of more than local concern. To say the most, a municipality has only qualified rights so to dispose of sewage as to pollute the water-supply of a neighboring community.

Michigan has many big water problems to solve. These problems as unsolved are costing many lives. If, as is claimed by eminent authority, the economic loss due to typhoid in a single year in the United States is sufficient to render the water-supply of every city, village and hamlet safe, it behooves us in Michigan to advance along this line.

I know I am expressing the sentiment of the State Board of Health when I say that it is not proposed to use the authority expressed in this law to the undue disadvantage of any municipality or individual. The purposes of the law are valuable and far-reaching, and only by cooperated efforts can the best results be secured. We are anxious that the state sanitary engineer be considered a public servant rather than an official. We extend to every "municipality, private corporation, partnership and individual" in Michigan his services of judgment and advice to the end that we may discontinue drinking our sewage and reduce to a minimum our typhoid rate even as it has been done in other places by the application of similar principles of sanitation and civilization.

Any one desiring a copy of the Montieth bill can obtain one by addressing the request to the Secretary of the State Board of Health, Lansing.

Book Notices

DISEASES OF THE NOSE, THROAT AND EAR. For the use of Students and General Practitioners by Francis R. Packard, M.D. Professor of Diseases of the Nose and Throat in the Philadelphia Polyclinic Hospital and College for Graduates in Medicine; Aurist to the Outpatient Department of the Pennsylvania Hospital. Second Edition with 145 Illustrations. Philadelphia and London, J. B. Lippincott Company, 1913. $3.50 net.

The needs of students have been especially considered in this edition, theorical matters being largely omitted, but the essentials of examination, etiology, diagnosis and treatment are carefully given. The division of the various topics is logical and calculated to clearness of presentation: pathological anatomy, etiology, symptoms and diagnosis, prognosis, treatment, being presented when possible and in this order. While the text is concise, it is clear and enters into sufficient detail, without theorizing. Necessarily many topics are omitted and others considered only casually, but in each instance the preference is given those topics of more immediate interest to the specialist, the student, the postgraduate student. The labryinth, for instance, receives only a very few pages, whereas vasomotor rhinitis (hay-fever) is considered in considerable detail. The illustrations are good, the style pleasant and the book is a valuable addition to any library, whether that of a specialist or general practitioner.

VACCINE AND SERUM THERAPY: Including a Study of Infections, Theories of Immunity, Specific Diagnosis and Chemotherapy. By Edwin Henry Schorer, B.S., M.D., Dr. P.H. Second Edition, 299 pp. Cloth. Price, $3.00. The C. V. Mosby Co., St. Louis, Mo.

The first edition of this work appeared in 1909 and the author now presents us with an entirely rewritten edition with many pages added.

The hope that is held out by vaccine and serum therapy makes it requisite that every physician should possess sufficient knowledge of the subject so as to decide when the vaccine and sera are to be given and what results are to be expected from their use. In this work the author presents the subject concisely and fairly and it should be of the most assistance to the practitioner. The work is commended. In fact, you cannot afford to be without it.

MIND AND HEALTH, With an Examination of Some Systems of Divine Healing. By Edward E. Weaver, Ph.D., Sometime Fellow in Clark University. With introduction by G. Stanley Hall, Ph.D., LL.D., President of Clark University. The MacMillan Company, New York. 500 pages. Cloth.

The reviewer is reminded of an expression gotten off by a wiseacre apropos of something or other. "If anyone likes this sort of thing, it is just the sort of thing he would like." One interested in the sort of material of which this book is composed will surely find much to gratify any morbid curiosity entertained as to the pedigree and early life of Quimby, the spiritual evolution of Dowie, the why of Mary Baker Eddy and the wherefore of most of the pseudo-religio-medical systems, particularly those of recent years, which

have afflicted the human family. There is no question of the author's sincerity and complete faithfulness to his self-imposed duty. He certainly gives chapter and verse. His bibliography covers fifteen closely written pages and extracts from the writings of those who have approved or disapproved, been indifferent to, apologetic for, or receptive of the outgivings of various healers, and the doctrines of mind-wrecking cults are quoted *in extenso*. To justify the appearance of another "system" of healing outside the bounds of legitimate medicine, one would, no doubt wisely, point out the good resulting from the application of faith whether in miracle-working at the shrine of some saint, in the "divine healing" of Dowie, or in the Eddyistic philosophy of love, and negation as to boils and ingrowing toenails.

In this book the reader is treated, on many occasions, to the threadbare story about the doctor who had thrown up his hands (which no doctor worthy of the name ever does), and whose patient, by him condemned to death, was restored through fervent prayer of the minister summoned at the critical time. Dr. Weaver's English is, for the most part, good, and substituting "The services of the faithful dominie" for the "Six bottles of" something he would have the average patent medicine advertisement beaten four ways.

It is not the object of the reviewer to disparage any effort to uplift the depressed by the exercise of faith, or to cast ridicule upon the efficacy of prayer. It is the dependence on a sole reed—more or less fragile—against which he would inveigh. Most systems advocating faith and prayer in healing leave out of account the medical man and the medical and surgical agencies. The wise physician will bring to his assistance the good offices of the priest, but the minister is invading the domain of the physician who exploits a system of healing the basis of which is faith. Too many such systems are already in existence, and the already befoozled public mind can stand no more. The physician himself should recognize the spiritual side of his calling, cultivate in the patient a philosophic attitude toward suffering, and encourage optimism as to the outcome of disease. When his own faith is inadequate to carry conviction, he may summon the pastor, but should himself be the judge of the need of the latter's services and will know the limitations of his armamentarium. He will also be alive to the danger of emphasizing too strongly the emotional side and inculcating indifference to the purely physical.

Dr. G. Stanley Hall in the introduction says: "One need not, and, indeed, perhaps no one would entirely agree with all the conclusions of the author on all the topics treated here, but I see no reason why religion, which in past ages has always exerted such a profound influence on all matters of health and disease, cannot rehabilitate for itself, from material herein described, its old function of healing which, when it is complete, will have profound significance on the future fate and function of the church."

The reader, especially the medical reader, should feel profoundly grateful to Dr. Hall for this permission not to believe, for example, in the author's "valid religious system" and "the power of healing released through a religious psychotherapy . . . mediated by the minister of religion." The author alleges: "One reason why the average Protestant minister isn't more eagerly sought by the people of his church and by men in general who need both bodily and mental help, is that he himself is not a reservoir of healing, reviving and regenerating power." Could the average minister, be he Protestant, Catholic or Jewish, with modesty lay claim to such repletion?

"While pastor of a church in one of our large cities, a member of the church came to the writer for advice as to non-medical treatment of a very painful ear. Being thrown into intimate contact with some people who were adherents of one of the new cults of healing, and judging their belief in some respects misleading, she refused to take the treatment of their cult. She was in doubt about the Christian propriety of any mental treatment. A few words made plain to her the legitimacy of such help for the Christian. She had already experienced partial relief. She had hit upon it in her Christian privileges of faith and prayer, greatly to her surprise, puzzled delight and unmixed gratitude. It was by the same means that she secured further relief and material assistance for the speedy and final cure of her trouble."

Could anyone who was a discriminating and safe counsellor advise any "non-medical treatment" for earache? If so, how about toothache?

CLINICAL LABORATORY METHODS. A Manual of Technic and Morphology Designed for the Use of Students. By Roger Sylvester Morris, A.B., M.D., Assistant Professor of Medicine, Washington University, St. Louis. Formerly Associate in Medicine, The Johns Hopkins University, etc., etc. 343 pages, cloth. Price, $3.00. D. Appleton & Co., New York.

This book is just what its title implies. One of the good practical manuals. It gives in detail the means employed in detecting the abnormal in urine, gastric contents, feces, blood, sputum and puncture fluids. The author has selected the best method for each examination, basing this selection on his experience and the proved value of that particular technic.

Laboratory aid in diagnosis is called for very frequently. Technic has been developed and more accurate deductions are obtainable. To the student or practitioner this manual will be of incalculable value as a laboratory guide. It supplies a want, for there has been need of such a book.

GOLDEN RULES OF DIAGNOSIS AND TREATMENT OF DISEASES. Aphorisms, Observations and Precepts on the Method of Examination and Diagnosis of Diseases, with Practical Rules for Proper Medical Procedure. By Henry A. Cables, B.S., M.D., Professor of Medicine and Clinical Medicine, College of Physicians and Surgeons, St. Louis. Second edition. Revised and rewritten. Cloth. 317 pages, $2.25. D. V. Mosby & Co., St. Louis.

What has been said about the other volumes of the Golden Rule series is applicable to this volume on medicine. The work has been entirely rewritten and the typographical construction has been reset. Chapters on infectious diseases have been added and new rules have been added where the author's experience has demonstrated that they were of value. It has been a very successful book, and since its revision it should prove of greater value. This book should not take the place of text-books covering a given subject more

fully. It serves to supply the busy physician with a quick reference to essentials until he has the available time for more extensive reading. It is a desk handbook.

SURGERY OF THE EYE. A Handbook for Students and Practitioners. By Ervin Török, M.D., Surgeon to the New York Ophthalmic and Aural Institute; Ophthalmic Surgeon to Beth Israel Hospital; Consulting Ophthalmologist to the Tarrytown Hospital, and Gerald H. Grout, M.D., Assistant Surgeon to the New York Ophthalmic and Aural Institute; Instructor in the Eye Department, Vanderbilt Clinic; Consulting Ophthalmologist to the Bellevue Hospital, First Division. Octavo, 507 pages, with 509 original illustrations, 101 in colors, and two colored plates. Cloth, $4.50 net. Lea & Febiger, publishers, Philadelphia and New York, 1913.

The eye is one of the most important and delicate organs of the entire body, and the successful treatment of its diseases and injuries requires great skill and precision. As a large part of ophthalmic work is of a surgical nature, it is important that those interested in it should have in convenient form a practical statement of those operations which have yielded the best results. Such a book is of even greater value and importance to the general practitioner, who is almost certain at some time to be called on unexpectedly to treat some injury to the eye because of its urgency.

This volume may claim two especially attractive features, its arrangement and its wealth of illustrations. The following plan has been pursued throughout the book: First, before describing each group of operations the authors have discussed the disease for the relief of which they are intended, and have given clear indications for the selection of the proper procedure in any given case. A detailed description of the steps of each operation then follows, with a list of all the instruments required. After this the complications that may occur at the time of operation and later are taken up, together with the post-operative care of the patient.

The authors have included all operations in common use to-day and also others that in their personal experience have given good results. This experience comprises fifteen years of practical work in Budapest, at the Royal Hungarian University Eye Clinic, with Prof. W. von Schulek, Prof. E. von Grosz and Prof. L. von Blaskovics; in Berlin with Prof. J. Hirschberg, and in New York at the New York Ophthalmic and Aural Institute, with Drs. Herman Knapp and Arnold Knapp.

The illustrations are all new and original, and over 100 are in colors. They have been used unsparingly wherever it was possible to elucidate the text.

The work is commended to both student, practitioner and specialist.

THE NARCOTIC DRUG DISEASES AND ALLIED AILMENTS. Pathology, Pathogenesis and Treatment. By George E. Pettey, M.D. 516 pages, cloth. F. A. Davis Company, Philadelphia.

The fact is often forgotten that drug habitués are, in most cases, the victims of disease and that they merit sympathy and are entitled to rational and skilful medical aid, such as is accorded the sufferer from any other physical ailment. The outlining of a rational and skilful medication for these conditions is the basis of this commendable work. The author treats the narcotic addiction as a disease the management of which belongs to the field of internal medicine, not to neurology.

This monograph devotes considerable space to the treatment of acute ailments that occur in narcotic and alcoholic habitués, and properly dwells on the vital and essential principle of the necessity of elimination, and with the outlining of auxiliary lines of treatment he furnishes a rational basis for the scientific and humane management of these cases.

There are so many excellent and commendable features in this book that the reviewer is unable to even enumerate them without utilizing more space than these columns will permit. Suffice it to say that this volume should be in the possession of every practitioner. It is a work that should receive a cordial reception and we wish that every practitioner in Michigan would read it.

New and Nonofficial Remedies

Since publication of New and Nonofficial Remedies, 1912, and in addition to those previously reported, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with "New and Nonofficial Remedies":

CHOLERA AGGLUTINATING SERUM.—The dried blood-serum of horses which have been injected with killed cultures of the cholera vibrio. It is intended for the diagnosis of cholera by the agglutination of suspected cholera vibrios. H. K. Mulford Co., Philadelphia (*Jour. A. M. A.*, May 10, 1913, p. 1461).

DIPHTHERIA BACTERIN.—This is a *Bacillus Diphtheriae* vaccine claimed to be useful for the treatment of diphtheria-carriers and for immunization against diphtheria. H. K. Mulford Co., Philadelphia (*Jour. A. M. A.*, May 10, 1913, p. 1461).

COLI VACCINE (POLYVALENT).—For description of *Bacillus coli* vaccine see N. N. R., 1913, p. 221. Schieffelin & Co., New York (*Jour. A. M. A.*, May 10, 1913, p. 1461).

GONOCOCCUS VACCINE (POLYVALENT).—For description of gonococcus vaccine see N. N. R., 1913, p. 223. Schieffelin & Co., New York (*Jour. A. M. A.*, May 10, 1913, p. 1461).

PNEUMOCOCCUS VACCINE (POLYVALENT).—For description of pneumococcus vaccine see N. N. R., 1913, p. 224. Schieffelin & Co., New York (*Jour. A. M. A.*, May 10, 1913, p. 1461).

STAPHYLOCOCCUS VACCINE (POLYVALENT).—Schieffelin & Co., New York (*Jour. A. M. A.*, May 10, 1913, p. 1461).

STAPHYLOCOCCUS ALBUS VACCINE (POLYVALENT).—Schieffelin & Co., New York (*Jour. A. M. A.*, May 10, 1913, p. 1461).

STAPHYLOCOCCUS AUREUS VACCINE (POLYVALENT).—For description of staphylococcus vaccine see N. N. R., 1913, p. 225. Schieffelin & Co., New York (*Jour. A. M. A.*, May 10, 1913, p. 1461).

STAPHYLOCOCCIC CULTURES.—These cultures consist of colonies of active living *Staphylococcus aureus*. They are intended for the elimination of diphtheria bacilli from the throats of diphtheria-carriers. H. K. Mulford Co., Philadelphia (*Jour. A. M. A.*, May 10, 1913, p. 1461).

LUMINAL.—Luminal is phenylethylbarbituric acid. It is closely related to veronal, which is diethylbarbituric acid. It is a white, slightly bitter powder, almost insoluble in cold water. It is claimed to be a useful hypnotic in nervous insomnia and conditions of excitement of the nervous system. Merck & Co., New York (*Jour. A. M. A.*, May 17, 1913, p. 1541).

LUMINAL SODIUM.—Luminal sodium is the sodium salt of luminal. It is hygroscopic and readily soluble in water. It is used for hypodermic injection in 20 per cent. solutions. Merck & Co., New York (*Jour. A. M. A.*, May 17, 1913, p. 1541).

MAGNESIUM PERHYDROL.—A name applied to magnesium peroxid (see New and Nonofficial Remedies, 1913, p. 185). Merck & Co., New York (*Jour. A. M. A.*, June 7, 1913, p. 1792).

MAGNESIUM PERHYDROL, 25 PER CENT.—A mixture consisting essentially of magnesium peroxid, magnesium oxid with water of hydration, containing not less than 25 per cent. of magnesium peroxid. Its properties, actions and uses are the same as those for magnesium peroxid. Merck & Co., New York (*Jour. A. M. A.*, June 7, 1913, p. 1792).

MAGNESIUM PERHYDROL, 25 PER CENT. TABLETS, 7½ GR.—Each tablet contains magnesium perhydrol, 25 per cent., 0.5 gm. Merck & Co., New York (*Jour. A. M. A.*, June 7, 1913, p. 1792).

LUMINAL.—(For properties, actions and uses see *Jour. A. M. A.*, May 17, 1913, p. 1541.) Farbenfabriken of Elberfeld Co., New York (*Jour. A. M. A.*, June 7, 1913, p. 1792).

LUMINAL TABLETS 1½ GRS.—Each tablet contains luminal 0.1 gm. Farbenfabriken of Elberfeld Co., New York (*Jour. A. M. A.*, June 7, 1913, p. 1792).

LUMINAL TABLETS, 5 GRS.—Each tablet contains luminal 0.3 gm. Farbenfabriken of Elberfeld Co., New York (*Jour. A. M. A.*, June 7, 1913, p. 1792).

LUMINAL-SODIUM.—(For properties, actions and uses see *Jour. A. M. A.*, May 17, 1913, p. 1541.) Farbenfabriken of Elberfeld Co., New York (*Jour. A. M. A.*, June 1913, p. 1792).

The Truth About Medicines

It is the purpose of this department to encourage honesty in medicines, to expose frauds and to promote rational therapeutics. It will present information regarding the composition, quality and value of medicaments, particularly as this is brought out in the reports of the Council on Pharmacy and Chemistry and of the Chemical Laboratory of the American Medical Association.

DUKET CONSUMPTION CURE.—Ex-Senator Wm. Lorimer who is financing the Duket Consumption Cure has asked the governors of all states to send a representative to Chicago to watch the "cure." It is also stated that he has induced the U. S. Public Health Service to make an investigation. After graduating from the Hahnemann Medical School of Chicago in 1893 and practicing in several states Dr. Duket opened the "Tubercular Sanatorium Company" at Findlay, Ohio, where he used a so-called serum said to be an "antiseptic lymph" which was stated not to be made from any tubercle bacilli and to be used intravenously. The Duket "cure" is being foisted on the public by a man who has no scientific standing and has had little or no scientific training. (*Jour. A. M. A.*, May 10, 1913, p. 1476.)

TONGALINE.—Tonga is said to consist of a mixture of roots and barks which was first used by the "medicine men" of the Fiji Islands. While its therapeutic inefficacy soon became apparent the word tonga has been perpetuated by calling a salicylate mixture "Tongaline." Each fluidram has been claimed to contain: fluid tonga, 30 grs.; extract of cimicifuga racemosa, 2 grs., sodium salicylate, 10 grs.; pilocarpin salicylate, 1/100 gr., and colchicin salicylate, 1/500 gr. Some of the claims for Tongaline are: "It cures rheumatism, neuralgia, grippe, gout, headaches, malaria, sciatica, lumbago, tonsillitis, heavy colds and excess of uric acid." The greatest objection to the use of such a nostrum by the medical profession is that it prostitutes the science of medicine and sets back the clock of therapeutic progress (*Jour. A. M. A.*, May 10, 1913, p. 1476).

ELIXIR TONGA COMPOUND.—The extensive advertising of Tongaline has kept alive a feeling that tonga has certain valuable—if mysterious—properties. As a result almost every large pharmaceutical house puts out a tonga preparation in the hope of reaping some financial benefit from the advertising of Tongaline. If Tongaline were not advertised, tonga would be forgotten and relegated to the therapeutic scrap-heap. Most of the tonga mixtures appear in the form of compound elixir of tonga, which are said to contain tonga, but depend on their action in the main on the salicylates which they contain (*Jour. A. M. A.*, May 10, 1913, p. 1478).

COLLYRIUM, WYETH.—In reply to an inquiry regarding the composition of Wyeth's Collyrium, the manufacturers write that "being a corporation" they "are not at liberty to disclose the various formulas" of their preparations. In other words, John Wyeth & Brother expect physicians of this country to prescribe "patent medicines" of whose composition they must be ignorant. Analysis of Collyrium, Wyeth, in the A. M. A. Chemical Laboratory showed its composition to be essentially: antipyrin, 0.41 gm.; sodium borate, 0.55 gm.; boric acid, 2.14 gm., and water to make 100 c.c. The secret of such a formula must indeed be a "valuable asset" (*Jour. A. M. A.*, May 17, 1913, p. 1557).

DIATUSSIN.—According to an advertising circular issued by E. Bischoff & Co., purporting to be a "reprint from the *Munich Medical Weekly*," Diatussin is " . . . a dialysate of herbe thymi and pinguiculae." The latter is said to be known in the Alps as "blue fatweed." The only further information as to the

composition of this preparation is the statement that "the dialysate of this blue fatweed is said by the manufacturer to contain a proteolytic ferment." The writer of the article speaks of a "procession of mothers" with their children affected with whooping-cough who came to him from a neighboring village. Yet he admits that the small number of cases which he has had permit of no definite conclusions and that his article is written to interest others in the nostrum (*Jour. A. M. A.*, May 17, 1913, p. 1558).

BANNERMAN'S INTRAVENOUS SOLUTION.—Bannerman's Intravenous Solution is put on the market by a man who is neither a physician or a pharmacist and whose only claim to medical knowledge is that of being a horse doctor. It was first exploited as a cure for consumption and has been known by the various names: "Tubercular Solution," "Germicidal Solution" and "Intravenous Solution." It is now sold as a cure-all. The following meaningless and impossible formula has been ascribed to the preparation: Each 10 c.c. of Bannerman's Solution contains: acid salicylic, 2 grs.; hydrargyrum albuminate, 1/9 gr.; ferrum, 4¼ grs.; sodium chlorid, 6 1/5 grs.; calcium carbonate, 2 grs.; phenol group, 1/25 gr. The claims made for Bannerman's Intravenous Solution are both false and fraudulent. It is a product the use of which appeals chiefly to cupidity and ignorance (*Jour. A. M. A.*, May 31, 1913, p. 1724).

VALUE OF AMMONIUM CARBONATE.—In prescribing for bronchial ailments the primary thought should always be not to give the patient anything that will cause nausea and vomiting. This is particularly true with babies and children. Ammonium carbonate is always irritant. As an expectorant it has no advantage over ammonium chlorid, and as a cardiac stimulant is more or less of a failure. Ammonium carbonate can stimulate the heart or raise the blood-pressure only by irritating the throat, gullet and stomach and may cause vomiting (*Jour. A. M. A.*, June 7, 1913, p. 1792).

PRESCRIPTION NONSENSE.—A mixture containing quinin sulphate, strychnin sulphate, diluted hydrochloric acid, glycerin and pepsin has been recommended for bronchial pneumonia in which there is respiratory failure. With a very sick child the cerebral irritation from quinin is not advisable, unless it is positively needed. This prescription is so intensely bitter that a child 5 years old will reject it. Also, quinin inhibits the digestive properties of pepsin. If strychnin is positively needed it would be better to administer it hypodermically (*Jour. A. M. A.*, June 7, 1913, p. 1792).

HAY-FEVER VACCINATION.—Clowes of the State Institute for the Study of Malignant Disease, at Buffalo, has observed that sufferers from the American or autumnal form of hay-fever are sensitive to extracts of rag-weed pollen. As a result, an attempt has been made in the Buffalo institution to produce immunity against autumnal hay-fever by vaccination. The favorable results obtained warrant further investigation. The dosage of the extract must be regulated with care as it is not devoid of dangerous possibilities and the uninitiated must be warned against over enthusiasm as the entire matter is in the experimental stage (*Jour. A. M. A.*, June 7, 1913, p. 1796).

MANAGING THE DETAIL MAN.—To reduce the nuisance of the detail men and their samples, the Evanston (Ill.) Pharmacologic Society has appointed a committee to whom detail men must present their case, before they will be received by the other members. This method of dealing with the proprietary question indicates that the physicians of Evanston are alive to their responsibilities. Would it not be simpler and just as efficient, however, to accept the findings of the Council on Pharmacy and Chemistry as constituting credentials for the detail man? Many physicians are using New and Nonofficial Remedies for just this purpose (*Jour. A. M. A.*, June 7, 1913, p. 1812).

SCOPOLAMIN IN LABOR.—A few years ago it was proposed to use morphin and scopolamin (hyoscin) in labor and give a sufficient amount to render and keep the patient in a semiconscious state. This plan was tried out in several German clinics but seems to have been generally abandoned (*Jour. A. M. A.*, June 7, 1913, p. 1814).

UTERINE HEMORRHAGE

1. No treatment of uterine hemorrhage can be rational, unless the cause is established; the empirical administration of hemostatic drugs is frequently useless, and indiscriminate curetting is dangerous.

2. The menorrhagia that occurs in young girls at the age of puberty is probably due to the association of functionally mature ovaries with a deficient uterine musculature. It tends to spontaneous cure, and should be treated by rest and, if possible, removal to a higher altitude.

3. Hemorrhage in young women may be due to mucous polypus, adenomatosis uteri, or bacterial infections of the uterus.

4. A practical method of investigating the bacteriology of the uterus is by the collection of the menstrual blood.

5. Hemorrhages at the menopause are frequently the result of increased arterial tension, portal obstruction, or degeneration and fibrosis of the uterus secondary to arteriosclerosis. It is probable that some cases of fibrosis uteri are syphilitic in origin. Treatment must be to reduce vascular tension. Ergot usually fails, and it may be necessary to remove the uterus.

6. Faults in the calcium metabolism may be the cause of obscure uterine bleeding, which may be cured by discovery of the cause and the administration of calcium salts. Occasionally, the combination of thyroid tissue with calcium is beneficial.

7. In every case of uterine hemorrhage, it is essential to look for a general cause before the local pelvic condition is investigated.—Whitehouse, *The Practitioner.*

RETROFLEXION OF THE UTERUS

1. Simple mobile retroflexion of the uterus seldom, if ever, causes symptoms.

2. A patient with a mobile retroflexed uterus, suffering from any of the symptoms mentioned in this paper, who has not been improved with a course of drugs, should have the uterus dilated and curetted.

3. Any fixation operation is unjustifiable in these cases until curettage has been given a trial.

4. If curettage has failed to improve the condition within twelve months of the operation, a fixation operation may be advised.

5. In almost all the cases in which curettage has failed, some condition, other than simple retroflexion, will be found.—Donald, *The Practitioner.*